Form Approved
OMB No. 0938-[illegible]

ONE TIME AUTHORIZATION

NAME OF BENEFICIARY ____________________ HI CLAIM NUMBER ____________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ____________________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

DO NOT MAIL THIS FORM IN — Retain in Patient's File in your office.

____________________ Patient's Signature

____________________ Date Signed

37-260 10/82