301-585-8828 Donna M. Firer, LCSW-C
7034 Carroll Avenue, Suite #1
Takoma Park, Maryland 20912
www.donnafirer.net


# MEDICARE / MEDIGAP CONSENT

**PART 1: Your Medicare Insurance**

Name of Client _____

Date of Birth ____/_____/_____ Medicare ID# _____

"I request that payment of authorized Medicare/Health insurance benefits be made either to me or on my behalf to the name of provider of service and (or) supplier of any services furnished to me by that provider of service and (or) supplier. 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."

Signature of Client/Guardian _____ Date ____/_____/____

**PART 2: Your Medigap or Secondary Insurance**

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of Medicare information about me to release any needed information for the payment of services rendered to:"

Name of Client _____ Date of Birth ____/_____/____

If the insured is different than the client, please provide complete name, date of birth, address & telephone information:

Name of Insured _____ Date of Birth _____

Address _____

Telephone _____

Medigap/Secondary Insurance provider _____

Membership ID# _____

Signature of Client/Guardian _____ Date ____/_____/____