



MEDICARE STATEMENTS

In accordance with Medicare Carrier Manual (MCM) 3047.3, Medicare beneficiaries must authorize the filing of claims (your benefits). Please review the following statement and sign your agreement:

“I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Therapy Network for any services furnished me by that facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits for the benefits payable for related services.”

Name of Beneficiary

HICN

Signature of Beneficiary

Date

MEDIGAP Statement (Must be signed if patient has insurance secondary to Medicare)

“I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to The Therapy Network for any services furnished to me by that facility. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

Name of Beneficiary

HICN

Signature of Beneficiary

Date