LIFETIME SIGNATURE AUTHORIZATION

MEDICARE CERTIFICATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that this authorization also apply to all other insurance.

Signed_____Date_____

By_____

Title or Relationship_____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____

_____

LIFETIME SIGNATURE AUTHORIZATION

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____

Subscriber's Signature Date

I authorize payment of medical benefits to the undersigned physician or supplier for services described.

_____

Subscriber's Signature Date

_____

Physician/Supplier Date