MEDICARE SIGNATURE ON FILE

Name of Beneficiary: _____

Medicare Claim #_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Associates in Dermatology, Inc.** for any service furnished to me by the listed medical practice. I authorize release to the Health Care Financing Administration and its agents any medical information about me to determine the payments for related services.

_____ Date:_____

Signature of Beneficiary