



MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

**Centers for Medicare & Medicaid Services
Medicare Authorization Form**

By law, Medicare is required to protect your personal medical information.

Medicare has the right to use and give out (“disclose”) your personal medical information to pay for your health care and to operate the Medicare program. For example, Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, to provide customer services to you, or to resolve any complaints you have. Medicare may also use or give out your personal medical information in other limited circumstances, such as for law enforcement purposes or for research studies that meet all privacy law requirements. For any other purpose, Medicare may only disclose your personal medical information with your written permission (“authorization”).

You can authorize Medicare to disclose your personal medical information to someone you know by completing the form and signing below. Return to:

*Palmetto GBA
P.O. Box 100222
Columbia, SC 29202 – 3222
1-800-633-4227*

[SECTION 1]:

Name of Beneficiary

Medicare Number

I authorize Medicare to disclose this personal medical information:

- All Medicare Information **or**
Check one or more of the following:
- One service only Date of service: _____
Doctor/supplier: _____
- All services on these date(s): _____
- All services from these doctor(s) or supplier(s): _____

(Name of provider/supplier)

- Medicare eligibility information
- Information on other health coverage
- Deductible information for the year of: _____
- Copy of Medicare Summary Notice for:

Date of Service	Doctor / Supplier/Hospital / Facility
_____	_____
_____	_____

Other (please specify):

[SECTION 2]:

Please write the name of the person, agency, company or organization, including address and telephone number, to whom you are authorizing Medicare to disclose your personal medical information:

Purpose of the disclosure – the reason why you want Medicare to release information to the person, agency, company or organization listed above (if you do not want to provide a statement of the purpose, describe the use as “at the request of the individual”):

The time period, subject to applicable law (Please check one):

- One time release
- Specific time period for release from: _____ to _____
- Specific services only: _____ (for example, physician claims only, hospital claims or medical equipment claims)
- Duration of Medicare enrollment

I authorize the use of a copy (including electronic copy) of this form and the disclosure of my personal medical information described above. I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

[SECTION 3]:

Signature of Beneficiary or Authorized Representative* **Date** **() Telephone Number**

*If you are signing as an authorized representative, please describe the basis for your authority to act for the beneficiary and attach appropriate documentation (for example, Power of Attorney or Appointment of Representative)

PLEASE NOTE:

Your personal medical information that you authorize Medicare to disclose may be subject to re-disclosure and no longer protected by law.

You have the right to take back (“revoke”) your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, you must send the request in writing to:

*Palmetto GBA
P. O. Box 100222
Columbia, SC 29202*