Please complete this section if you have Medicare or a Medicare Replacement Plan

Statement to Permit Payment of Medicare Benefits to Provider Physicians and Patients

I request that payment of authorized Medicare benefits be made wither to me or on my behalf for any services furnished me by Kidney Care of Michiana, LLC. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits for related services.

_____ _____

Signature Date

_____ _____

Printed Name Medicare Number

Please complete this section if you have a Commercial/Supplemental Insurance or Medicaid

I request that payment of authorized Insurance Carrier be made to either to me or on my behalf to Kidney Care of Michiana, LLC for any services furnished to me by Kidney Care of Michiana, LLC. . I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits for related services.

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

_____ _____

Signature Date

_____

Printed Name