

**CLINTON SERVICE UNIT**

**ASSIGNMENT OF MEDICARE BENEFITS AND AUTHORIZATION TO BILL MEDICARE**

I request that payment of authorized Medicare benefits be made upon my behalf to the Clinton Service Unit which includes Clinton Indian Health Center, El Reno Indian Health Center and Watonga Indian Health Center for services furnished to me by the Clinton Service Unit. I authorize possessors of my personal medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or agency.

Name of Patient \_\_\_\_\_

Medicare Policy Number: \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Health Record Number: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Date: \_\_\_\_\_

If the Medicare patient is physically or mentally unable to sign, please complete this section. The following are the only permissible authorized signers:

- Patient’s legal guardian, if patient is NOT a minor
- Patient’s Healthcare Power of Attorney
- Relative or other person who receives government benefits on behalf of the patient
- Relative or other person who arranges treatment or handles the patient’s affairs
- Representative of an agency or institution that furnished care, services, or assistance to the patient (i.e. Nursing Home, SNF, etc.):

Reason patient is unable to sign: \_\_\_\_\_

Name of Authorized Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Name of IHS CSU official: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of IHS CSU official: \_\_\_\_\_

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**REFUSAL TO ASSIGN MEDICARE BENEFITS AND AUTHORIZATION TO BILL MEDICARE**

Patient is physically and mentally capable of signing Medicare Assignment of Benefits and Authorization to Bill Medicare

Patient Refused to Sign

Reason for refusal as stated by patient: \_\_\_\_\_

As witnessed by the below stated IHS CSU official.

Name of IHS CSU official: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of IHS CSU official: \_\_\_\_\_