The Medical Center of Elberton, LLP

Medicare Lifetime Authorization

Statement to Permit Payment of Medicare Benefits to The Medical Center of Elberton, LLP, Rural Health Clinic

________________________________ ________________________________
(Patient Name) (Medicare Policy Number)

I request payment of authorized Medicare benefits on my behalf for any services furnished me by The Medical Center of Elberton, LLP. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits related for services.

________________________________ ________________________________
(Date) (Patient Signature)