Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE Date

_____ _____

SUPPLEMENTAL AUTHORIZATION TO RECEIVE PAYMENTS
(Sign ONLY ifyou have a Medicare secondary insurance)

PATIENT MEDICARE Identification Number:

_____

Name of Supplemental Insurance Policy Holder:

_____

SUPPLEMENTAL INSURANCE NAME:

_____

SUPPLEMENTAL INSURANCE POLICY NUMBER:

_____

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Minidoka Medical Center/Rural Health Clinic for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to Minidoka Medical Center Any information needed to determine these benefits or the benefits payable for related services.

–

SIGNATURE DATE

_____ _____

# Health History

This is confidential information and will be used only for the purpose of your healthcare.

Name _____ _____ DOB _____
Today's Date

Allergies to medications? None o What happens?

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

Medications None o

Name of Medication Strength How many times a day do you take it?