



**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS  
TO PROVIDER, PHYSICIAN AND PATIENT**

**(FOR MEDICARE PATIENTS ONLY)**

I request that payment of authorized Medicare benefits be made on my behalf to APM Spine & Sports Physicians (APM) for any service furnished to me by APM. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Medicare Number

\_\_\_\_\_  
Beneficiary's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date