KEYSTONE
FAMILY COUNSELING

MEDICARE CLIENT AGREEMENT
(Required by Medicare for all Medicare claims)

ENTITLEE'S NAME: MEDICARE SUBSCRIBER NUMBER:

Request that payment of authorized Medicare benefits be made either to me or on my behalf to KEYSTONE FAMILY COUNSELING for any services furnished me by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
This authorization is in effect until I choose to revoke it in writing.

X_____

Client/Guardian Signature Date