Auburn Bay City Essexville

One Time Authorization Agreement

I,_____ Medicare Number_____ request that payment of authorized Medicare benefits be made either to me or on my behalf to Thomas M. Barba, MPT, for services furnished to me by that Physical Therapist. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Beneficiary Signature

_____

Date