



Name of Beneficiary

Health Insurance Claim Number#

Medigap Policy Number #

I request that payment of authorized Medigap benefits be made on my behalf to _____ for any services furnished by _____ . I authorize any holder of medical information about me to release to _____ any information needed to provide my supplemental insurer with information concerning this Medicare claim, because my signing authorization will cause Medicare payment information to cross over automatically.

Signature