UNION HEALTH SERVICE

1634 West Polk Street Chicago, Illinois 60612 (312) 423-4200 www.unionhealth.org

Medicare Authorization Form

UHS Chart# _____ Name_____ Male/Female

Birth date _____ Address _____

Phone# ( ) _____ City _____ State _____ Zip _____

Medicare Health Insurance Claim # _____ Group # _____

I HEARBY AUTHORIZE the Center for Medicaid and Medicare Centers (CMS), its intermediaries or carriers, to furnish information to the Union Health Service, Inc. affirming my entitlement to Hospital Benefits (Part A) and enrollment for Supplementary Medical Insurance Benefits (Part B) under Title XVII of Social Security Act and to furnish the plan information as to Part A and Part B benefits recorded, including those based on services not-furnished by or through the plan, of such termination for use in connection with the operation of this plan.

I also authorize the Union Health Service, Inc or any other holder of medical or other information about me to release to the CMS or its intermediaries or carriers any information needed to administer Title XVII of the Social Security Act. I permit Union Health Service, Inc. to use a copy of this authorization in place of the original when necessary.

I assign payment under the Supplementary Medical Insurance Program (Part B of Title XVII) to the Union Health Service, Inc. of Supplementary Medical Insurance Benefits payable on my account by that organization.

This assignment will continue as long as I remain a member of the aforementioned organization, or until cancellation written by me.

Part A Effective Date: _____ Signed: _____

Part B Effective Date: _____ Date Signed: _____

Questionnaire for Medicare Patients

Due to changes in Medicare, we ask your assistance in keeping our utilization figures correct by answering the following question:

If you have signed up for Medicare B (Medical Part):

Are you retired? Yes ( ) No ( )

If you are retired, do you work at all? Yes ( ) No ( )

If yes, please list the name, address and telephone # of your employer:

_____

If married, name of spouse: _____

Is your spouse working? Yes ( ) No ( )

If yes, please list the name, address and telephone# of your spouse's employer:

_____

Are you on disability Medicare? Yes ( ) No ( )

Should you wish to enroll at Union Health Service, Inc., utilizing your Medicare B as your primary Health Insurance Carrier, please sign below.

This is effective upon approval by the Center for Medicaid and Medicare Centers (CMS) and remains in effect unless cancelled by you in writing or you are deleted by CMS as an enrollee in Union Health Service, Inc. due to your enrollment in another plan (HMO) or loss of Medicare entitlement.

Signed: _____

Date: _____, 20_____