



APPLICATION

Name _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Phone () _____

Date of Birth _____

Social Security # _____

Medicare # _____

Other Insurance : _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Identification # _____

Spouse _____

Date of Birth _____

Social Security # _____

Medicare # _____

Other Insurance : _____

Dependents:	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL AUTHORIZATION/
ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, participating EMS agency, or any insurance company, any Information needed to determine Medicare benefits or the benefits payable for related services or any other type of insurance claim, now or in the future. I permit a copy of this authorization to be used in place of the original, and request that payment available under any insurance be made directly to the participating EMS agency.

Parents sign for minors.

Signature

Date

Spouse

Date

Please make your check for \$45 (\$40 if you are over 65) payable to your local EMS agency.

***If you have any questions, call us at
635-1789
and we will be happy to assist you.***

***Or write to:
MultiMed, P.O. Box 535
Baldwinsville, New York 13027-0535***