

## BENEFICIARY AUTHORIZATION FORM - RAILROAD MEDICARE

**INSTRUCTIONS:**

Please type or print all fields to process the Railroad Medicare Authorization Form.

Railroad Medicare cannot release information about the beneficiary without their permission. The beneficiary must complete and return this authorization form to the address below before we can discuss his or her Medicare benefits.

<b>Beneficiary Information</b>		<b>SEND COMPLETED FORM TO:</b>	
1	HEALTH INSURANCE CLAIM NUMBER  PREFIX            6 OR 9-DIGIT NUMBER  _____	<b>PALMETTO GBA</b> Railroad Medicare Part B Office P.O. Box 10066 Augusta, GA 30999-0001	
2	FIRST NAME  _____	MI  _____	LAST NAME  _____
3	DATE OF BIRTH  ____ / ____ / ____	<input type="checkbox"/> Male  <input type="checkbox"/> Female	PHONE NUMBER  (____) _____ - _____
4	STREET ADDRESS  _____	CITY, STATE & ZIP CODE  _____	
5	I give Railroad Medicare consent to give _____, (Name) my _____ information regarding my Medicare claims and benefits. (Relationship) HOW LONG WOULD YOU LIKE FOR THIS PERSON TO BE ABLE TO OBTAIN YOUR INFORMATION? <input type="checkbox"/> Until Further notice <b>OR</b> <input type="checkbox"/> From (start date) ____ / ____ / ____ To (end date) ____ / ____ / ____  <b>IMPORTANT!! If you do not choose one of the above, this consent will be valid for one year from the date shown below.</b>		
6	MEDICARE BENEFICIARY'S SIGNATURE	DATE  ____ / ____ / ____	

For additional assistance, please contact Customer Service at 1-800-833-4455. We are available Monday through Friday between the hours of 9:00 a.m. and 5:15 p.m. (Eastern Standard Time).