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MEDICARE SIGNATURE ON FILE UPDATE

Lifetime Authorization to Submit Medicare Claims

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to William F. Ganz, M.D., FACS, PLLC, dba Neurosurgery and Spine Northwest, for any services furnished to me by Dr. Ganz. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

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NAME OF BENEFICIARY

_____ _____

PATIENT SIGNATURE **DATE**