Rajiv Malik, M.D. Samir V. Kubba, M.D. Dennis A. Hilliard, M.D.





Patient Name:
Medicare Claim Number:
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr for any services furnished me by that physician. 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.
Signature
Date: