**LIFETIME SIGNATURE ON FILE FORM FOR MEDICARE CLAIMS (ONLY FOR MEDICARE PATIENTS)**

**Name of Beneficiary (Policy Holder): _____**
**Medicare Number: _____**
I request that payment of authorized Medicare benefits be made on my behalf to AMY HUBERMAN, MD for any services furnished by AMY HUBERMAN, MD. 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 to related services.
**Patient Signature: _____**