KINGSTON
PHYSICAL THERAPY
&
SPORTS REHAB P.C.

Name of Beneficiary

Health Insurance Claim Number (HICN)

X_____ X_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Kingston Physical Therapy and Sports Rehab, P.C.* for services furnished to me by the provider. 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.

X_____ X_____ _____ _____

Patient's Signature Date Provider's Signature Date