

BENEFICIARY AUTHORIZATION FORM - RAILROAD MEDICARE

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.

Beneficiary Information		SEND COMPLETED FORM TO:	
1	HEALTH INSURANCE CLAIM NUMBER PREFIX 6 OR 9-DIGIT NUMBER _____	PALMETTO GBA 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	MAILING 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 OR <input type="checkbox"/> From (start date) ____ / ____ / ____ To (end date) ____ / ____ / ____			
IMPORTANT!! If you do not choose one of the above, this consent will be valid for one year from the date shown below.			
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 8:30 a.m. and 4:30 p.m. for all time zones with the exception of PST, which receives service from 8 a.m. to 5 p.m.

How to fill out this Beneficiary Authorization Form

Palmetto GBA Railroad Medicare has always been concerned with protecting the privacy of the many beneficiaries that we serve, and one of the ways we do this is by making sure that your personal Medicare information is given out to the right people. Please complete the attached authorization form and return it to our office. Once we have received the form, we will document on your records any individual you have given consent to and send you an acknowledgment letter.

Follow these instructions carefully:

A. Completion of this form

- Item 1: Enter the beneficiary's Health Insurance Claim (HIC) number including the alpha prefix exactly how it is shown on the Medicare card.
- Item 2: Enter the beneficiary's name exactly as it is shown on the Medicare card.
- Item 3: Enter the beneficiary's date of birth, including month, day and year.
Check the appropriate box for the beneficiary's gender.
Enter beneficiary's telephone number (if available).
- Item 4: Print the beneficiary's current mailing address, including city, state and zip.
- Item 5: List the name of the person(s) you are giving consent to and their relationship to the beneficiary.
Please check the box indicating how long the consent is valid for. If the consent is only valid for a specific time period, please list the date that the consent should start and end.
- Item 6: Please have the beneficiary sign the form and enter the date that the form was completed.

B. Other authorization

We can also accept a copy of a Power of Attorney to list someone as authorized on the beneficiary's account. If you have a legal document that is signed and has a seal, if required by your state's laws, send a copy of the document to our office.

C. Deceased beneficiary

The authorization form is not valid after the beneficiary's death. If you are looking to be authorized on a beneficiary's account after their death, please contact our office for details on what documentation is required. You can contact us at 1-800-833-4455.