

4. Statement of Termination

This section is to be completed by the individual practitioner to terminate a previously authorized reassignment of benefits.

By my signature, I hereby terminate the authority of _____ to claim or receive any fees or charges for my services.
(Name of Individual or Provider/Supplier as Reported to the IRS)

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner Name	First	Middle	Last	Jr., Sr., etc.
Print				

Individual Practitioner Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed
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5. Reassignment of Benefits Statement

This section **MUST** be signed and dated by the individual practitioner shown in Section 3 to authorize the reassignment of his or her benefits to the provider/supplier shown in Section 2.

Medicare law prohibits payment for services provided by an individual practitioner to be paid to another individual or provider/supplier unless the individual practitioner who provided the services specifically authorizes another individual or provider/supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 CFR 424.73 and 42 CFR 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the individual or provider/supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or provider/supplier must be in compliance with CMS regulations. All individual practitioners who allow another individual or provider/supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

Individual Practitioner Name	First	Middle	Last	Jr., Sr., etc.
Print				

Individual Practitioner Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed
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6. Attestation Statement

This section requires the signature of an authorized or delegated official of the provider/supplier shown in Section 2. The authorized or delegated official must currently be on file with Medicare for this application to be processed.

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws. For new reassignments, I also certify that the provider/supplier requesting to receive payments is legally eligible to receive reassigned benefits per CMS regulations.

Authorized/Delegated Official Name	First	Middle	Last	Jr., Sr., etc.
Print				

Authorized/Delegated Official Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed
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7. Contact Person

This section is to be completed with the name, telephone number and address of a person who can answer questions about the information furnished in this application.

Name	First	Last	Telephone Number	(Ext.)
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Address Line 1 (Street Name and Number)

City	State	ZIP Code + 4
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