

SECTION 4: AUTHORIZATION STATEMENTS

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1.

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

Your employment or contract with this individual or supplier must be in compliance with CMS regulations and you must be in compliance with applicable Medicare program safeguard standards described in 42 C.F.R. 424.80. All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement. The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignment of benefits.

A. Individual Practitioner

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

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., etc. M.D., D.O., etc.
Individual Practitioner Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i>)			Date (<i>mm/dd/yyyy</i>)
SIGNED			

B. Authorized or Delegated Official

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

First Name	Middle Initial	Last Name	Jr., Sr., etc. M.D., D.O., etc.
Authorized or Delegated Official's Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i>)			Date (<i>mm/dd/yyyy</i>)
SIGNED			

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.