Schwieters Medical, PLLC
2781 Pilot Knob Road
Eagan, MN 55121
Phone: (651) 289-7300
Fax: (651)289-7301

Medicare Authorization

_____ _____/_____/_____
Printed Patient Name Date of Birth

_____
Medicare Identification Number

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to: Schwieters Medical, PLLC for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Responsible Party Date