Extended Signature Authorization Form

____________________ ____________________

Beneficiary's Name **HIC #**

I request that payment of authorized Medicare benefits be made on my behalf to **Advanced Mental Health Center, Inc.** for any services or items furnished to me by the practitioners in that group. I authorize any holder of medical information about me to release to Centers for **Medicare and Medicaid Services** and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance if indicated in item **9 of the CMS -1500 or HCFA-1500** claim forms or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or mental health clinic shown.

Signature: _______________ **Date:_______________**