

HCFA

MEDICARE • MEDICAID
Health Care Financing Administration

MEDICARE PART B

Medicare Part B Noridian Government Services

Request for Release of Information

This form is for the release of beneficiary information. The type of information to be released will be regarding Medicare claim(s) status (why a claim was or was not paid) and payment information.

BENEFICIARY INFORMATION (Person on Medicare)

Name: _____

Medicare Number: _____

Telephone Number: _____

What information to be released: any and all claim and policy information as requested

Time Frame: Ongoing Limited (give date range) _____ to _____

INDIVIDUAL TO ACT ON MY BEHALF

Name: Becki McKinney, Shannon Biondi, Medical Claims Service, or any of its representatives

Address: PO Box 1265, Redmond, OR 97756

Telephone Number: (541) 504-4676

BENEFICIARY SIGNATURE

DATE

If you have any questions regarding this form please contact us at:

CO: 1-800-332-6681
IA: 1-800-532-1285
ND: 1-800-247-2267
SD: 1-800-437-4762
WY: 1-800-442-2371

AK, AZ, HI, NV, OR, WA: 1-800-444-4606

Noridian Mutual Insurance Company
A HCFA Contracted Carrier/Intermediary
4305 – 13th Avenue South
Fargo, ND 58103