Claim No.: _____

CERTIFICATION OF MEDICARE ELIGIBILITY

State of: _____ **County of:** _____

1. Full First Name_____
2. Middle Initial_____
3. Last Name_____
4. My date of birth is _____.
5. Gender is ____Male ____ Female

6. Do you have a Social Security number ("SSN")? ____ Yes ____ No

   If yes, please provide your SSN _____

7. Maiden name or other name(s) under which you have used the above SSN _____

8. Do you have an Individual Taxpayer Identification Number ("ITIN")? ____ Yes ____ No

   If yes, please provide your ITIN _____

9. Are you a Medicare beneficiary? ____ Yes ____ No
10. Are you currently receiving Medicare benefits? ____ Yes ____ No
11. Are you eligible for Medicare benefits? ____ Yes ____ No

If you answered yes to question 7, 8 or 9, please provide your Medicare Health Insurance Claim Number _____.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to certain action by Medicare including but not limited to possible penalties and fines and/or recovery of any funds improperly paid to me by Medicare in connection with the above-referenced claim.

_____ _____

Signature Date

_____

Print Name