

Medicare Beneficiaries Signature on File Requirements

I request that payment of authorized Medicare benefits be made on my behalf to one of the following providers associated with Inland Orthopaedic Surgery and Sports Medicine for any services furnished me by that physician supplier:

Charles A. Jacobson, MD
Steven E. Pennington, MD
Edwin M. Tingstad, MD

I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature

Date