INTERNAL MEDICINE ASSOCIATES OF MIDDLE GEORGIA
CRAIG CALDWELL, M.D. JEREMY T. GOODWIN, MD.
TAMMY BARNETT, APRN, FNP-C

MEDICARE AUTHORIZATION

NAME OF BENEFICIARY: ____

MEDICARE NUMBER: ____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Internal Medicine Associates of Middle Georgia including physician services. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its agents or Carriers any information needed to determine these benefits or benefits of related services.

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