James C Ricketti, D.P.M

Brandon Bosque, D.P.M

Account number_____

" I request that payment of Authorized Medicare Benefits be made either to me or on my behalf to James C Ricketti, D.P.M. for any services furnished . I authorize any holder of Medical Information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Name of Beneficiary **Date**

I give my permission for Dr James C Ricketti D.P.M. and his staff to correspond with Medicare on my behalf concerning any and all of my Medicare Claims.

I give permission to Medicare to send the results of any appeals or reconsideration of my bills to Dr James C. Ricketti, D.P.M.

_____ _____

Name of Beneficiary **Date**

Medicare Patients Only