PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA
A CELERIAN GROUP COMPANY

RAILROAD RETIREMENT BOARD U.S.A.
A RRB-Contracted Specialty Medicare Administrative Contractor

Railroad Medicare Beneficiary Authorization Form

Use this form if you want Railroad Medicare to give your personal health information to someone other than you.

ALL fields are REQUIRED unless otherwise noted.

1. Information about the person with Railroad Medicare

Enter the name and Medicare Number exactly as they appear on the Railroad Medicare card.

First Name: | Initial: | Last Name: | Suffix:

Medicare Number: | Date of Birth *(MM/DD/YYYY):* | Telephone Number:

Address: (Street Address, City, State, Zip Code)

NOTE: This authorization form is not valid after a beneficiary's death. If you are looking to be authorized on a beneficiary's account after their death, please contact our office for details on what types of legal documentation can be accepted. You can call our Beneficiary Contact Center toll-free at 1-800-833-4455 from 8:30 a.m. to 7 p.m., Monday through Friday.

2. Information about the person(s) you give Railroad Medicare permission to release your personal health information to

Fill in the name, relationship and address of the person(s) or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below.

Name: | Relationship:

Address: (Street Address, City, State, and Zip Code)

Name: | Relationship:

Address: (Street Address, City, State, and Zip Code)

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3. Specific personal health information you want Railroad Medicare to disclose

☐ Any Information **OR** ☐ Limited Information (Choose all that apply)

- ☐ Information about your Medicare eligibility
- ☐ Information about your Medicare claims
- ☐ Other Specific Information (explain below):

4. How long would you like the person(s) you named to be able to obtain your information? (Choose one)

☐ Until Further Notice **OR**

☐ For the dates specified here *(MM/DD/YYYY)*: From / / to / /

If you do not choose one of the above options, the consent will be valid for one year from the signature date.

5. I authorize Railroad Medicare to disclose my personal health information listed above to the person(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) and may no longer be protected by law.

Signature: _____ Date: (*MM/DD/YYYY*) / /

☐ Check here if you are signing as a personal representative and complete below. Attach the appropriate documentation (for example, a copy of a valid signed and dated Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Personal Representative's Name: Telephone Number:

Address:

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Railroad Medicare has already acted based on your permission. To revoke authorization, send a written request to the address below. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

Please mail of fax this form and any additional information to

Fax: (803) 264-9844

Palmetto GBA - Railroad Medicare
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