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MEDICARE CLAIM REQUEST

All Medicare claims must be submitted for reimbursement by B&B Company. If you are eligible for Medicare and wish us to file a claim, please FILL OUT THE FOLLOWING INFORMATION IN FULL AND RETURN IT WITH YOUR DOCTOR'S PRESCRIPTION. Your claim will be promptly submitted to the Health Care Financing Administration from B&B Company. Any reimbursement will come to you directly. Please allow at least four weeks for processing.

Your Name _____ Phone (___) _____

Address _____ City _____ State _____ Zip _____

Your Medicare number, as it appears on your Medicare card, including ALL NUMBERS AND LETTERS:

_____

Your Date of Birth _____ Your Doctor's Name _____

Is Medicare your primary insurance carrier? Yes ☐ No ☐

Which breast was removed? Left ☐ Right ☐ Both ☐

I request payment of authorized Medicare benefits be made to me. 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.

Your signature _____

(As it appears on Medicare card)

B&B Company P.O. Box 5731 Boise, Idaho 83705 (208) 343-9696 (208) 343-9266/Fax

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