MEDICARE DATA FORM

You must complete (1) Section A and (2) either Section B, C, or D.

A. CLAIMANT DEMOGRAPHIC INFORMATION

(This section is required.)

Name	First	MI	Last	Suffix
SSN		**Gender**	☐ Male ☐ Female	
Date of Birth	__ / __ / ____ (month) (day) (year)	**Medicare Insurance Claim Number ("HICN"), if applicable.**		

B. CLAIMANT SIGNATURE

(This section is required if you filed the claim on your own behalf.)

I hereby certify under penalty of perjury that the information in this Form is true and correct.

Signature		**Date**	_____/_____/_____ (month) (day) (year)	
Name (printed or typed)	First	MI	Last	Suffix

C. SIGNATURE BY REPRESENTATIVE

(This section is required if the Claimant is deceased or legally incompetent and the claim was filed on the Claimant's behalf. Complete section using the representative's information, not the Claimant's information.)

I am authorized to complete this form on behalf of the Claimant and certify under penalty of perjury that the information in this Form is true and correct.

Signature		**Date**	_____/_____/_____ (month) (day) (year)	
Name (printed or typed)	First	MI	Last	Suffix
Address	Street/P.O. Box			
	City		State	Zip

D. CLAIMANT COUNSEL SIGNATURE

(Use in lieu of Claimant or Representative Claimant Signature only.)

I am counsel for the Claimant identified in this Form. I hereby certify, under penalty of perjury, that to the best of my knowledge and belief the information in this Form is true and correct.

Signature		**Date**	_____/_____/_____ (month) (day) (year)	
Name (printed or typed)	First	MI	Last	Suffix
Law Firm Name				