

**FRANK DeMENTO, M.D.**  
**AND ASSOCIATES, P.C.**  
520 Franklin Avenue, Suite 229  
Garden City, NY 11530

Telephone: (516) 746-1227

**SIGNATURE ON FILE**

Name of Patient:

Health Insurance Claim Number (HICN)

\_\_\_\_\_  
I request that payment of authorized Medicare benefits be made either to me or on my behalf to \_\_\_\_\_ for services furnished to me by the provider.

I authorize any holder of medical information about me to release to the Centers for Medicare and its agents any information needed to determine these benefits payable for related service.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date