



Teton Nuclear Medicine Service

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MEDICARE

SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Teton Nuclear Medicine Service* for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services, formerly the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Signature _____

Date _____