Claim No.: _____

CERTIFICATION OF MEDICARE ELIGIBILITY

State of _____ County of _____

1. First Name_____
2. Middle Initial_____
3. Last Name _____
4. Date of birth _____
5. Gender ____Male ____ Female

6. Do you have a Social Security number ("SSN")? ____ Yes ____ No

   If yes, please provide your SSN: _____

7. Maiden name or other name(s) under which you have used the above SSN _____
   _____

8. Do you have an Individual Taxpayer Identification Number ("ITIN")? ____ Yes ____ No

   If yes, please provide your ITIN _____

9. Are you a Medicare beneficiary? ____ Yes ____ No
10. Are you currently receiving Medicare benefits? ____ Yes ____ No
11. Are you eligible for Medicare benefits? ____ Yes ____ No
12. Are you receiving Social Security benefits at this time ____ Yes ____ No
    a. If no, have you applied for Social Security benefits? ____ Yes ____ No
13. Are you receiving Social Security Disability Insurance benefits ("SSDI")? ____ Yes ____ No
    If no, have you applied, been denied or are you appealing any SSDI determination?_____

If you answered yes to question 9, 10 or 11, please provide your Medicare Health Insurance Claim Number _____

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to certain action by Medicare, including but not limited to, possible penalties and fines and/or recovery of any funds improperly paid to me by Medicare in connection with the above-referenced claim.

_____ _____
Signature Date

_____
Print Name