



**Twin Falls Orthopedics, P.L.L.C.**  
**Orthopedic & Fracture Surgery**



John W. Howar, M.D.  
Frederick L. Surbaugh, M.D.  
R. Tyler McKee, D.O.  
Randal Wraalstad, D.P.M.  
Anna Hawker, F.N.P.

**MEDICARE ASSIGNMENT OF BENEFITS**

I request that payment of authorized Medicare benefits be made either to me or on my behalf, to Twin Falls Orthopedics, PLLC. for any services furnished me by Twin Falls Orthopedics, PLLC. I authorize any holder of medical information about me to release 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.

Patient Name (Printed)

Medicare Number

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**MEDIGAP ASSIGNMENT OF BENEFITS**

I request that payment of authorized Medigap benefits be made on my behalf, to Twin Falls Orthopedics, PLLC. for any services furnished me by Twin Falls Orthopedics, PLLC. I authorize any holder of medical information about me to release to \_\_\_\_\_ any information needed to determine these benefits.

(Name of Medigap insurer)

Patient Name (Printed)

Medicare Policy #

Date: \_\_\_\_\_

Signature: \_\_\_\_\_