GULF COAST
REHABILITATION SERVICES, INC.

Re: Name:

Date of Birth:

Social Security #:

I authorize the Social Security Administration to release information or records about me to:

Name Address
Gulf Coast Rehabilitation Inc.
P.O. Box 13798 Tampa, Fl. 33611

I want this information released because:
To determine if my case meets the CMS review threshold in order to protect Medicare's interests under the Medicare Secondary Payer Statute.
(There may be a charge for releasing information)
Please release the following information:
_____ Social Security Number
__**X**_Identifying information (includes date and place of birth, parent's names)
_____ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from _All Dates to _____
_____ Information about my Medicare claim/coverage from All Dates to _____
_____ Medical records
_____ Record(s) from my file (specify)
__**X**_ **Other** (specify) **Verify date of birth, Social Security entitlement status, date of SS entitlement or date of application if still pending, date of denial, date of appeal, status of appeal, basis for entitlement (disability or age), name of representative payee if assigned, number of eligible work quarters, if quarters adequate for Social Security benefits, Medicare status, date of entitlement for Medicare A and B.**

I am the individual to whom the information/record applies, parent or the legal guardian of that person. I know that if I make any representation, which I know is false to obtain information from Social Security, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names and address of two people if signed by mark)

Date: _____ Relationship: _____
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