Signature on File

Medicaid will follow Medicare policy and allow providers to obtain a lifetime authorization from the Medicaid recipient to submit Medicaid claims. This authorization may be retained in the provider's office and should read as follows:

Statement to Permit Payment of Medicaid Benefits to Provider

Medicaid Recipient's Name:	Medicaid ID Number:

I request that payment of authorized Medicaid benefits be made on my behalf to Southwest Mississippi Planning and Development District.

I authorize any holder of medical or other information about me to release to the Division of Medicaid or the fiscal agent any information needed to determine these benefits or the benefits payable for related services.

** This Authorization is Good for my Lifetime **

Recipient's Signature:	Date Signed: