Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

TO: Social Security Administration

Name	Date of Birth	Social Security #

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

Name
Express Scripts Medicare Set Asides

Address
6272 Lee Vista Blvd
Orlando, Fl 32822
T:800-985-3390
F:800-985-3391

I want this information released because:

To establish my Social Security Disability status and date of entitlement, my Medicare status and date of entitlement and the basis for entitlement (disability, age, ESRD) for the purpose of my Workers' Compensation claim.

(There may be a charge for releasing information)

Please release the following information:
_____ Social Security Number
_____ 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) **Social Security entitlement status, date of SS entitlement or date of application if still pending, basis for entitlement (disability, age, ESRD), Medicare status, date of entitlement for Medicare A and B, Supplemental Security Income entitlement, Medicaid entitlement. If not a current Social Security recipient, include number of eligible quarters. Please note if Medicare has paid any medical claims or filed any liens.**

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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