CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

SOUTH AUSTIN
MEDICAL CLINIC

Confirmation of Main Doctor or Other Healthcare Professional Form

1. CONFIRM

By signing below I am confirming that my main doctor or other healthcare professional—or the main place I go to for routine medical care—is:

Or scan QR code to submit this form online:

yesdoc.us/uwFqZqCt

Provider Name and/or Medical Group South Austin Medical Clinic

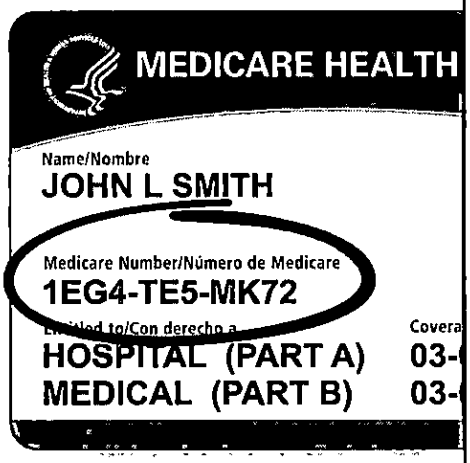
Beneficiary Name _____

X _____
Signature

_____
Date (Required)

_____
Print Name

_____
Medicare Number



Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, or to opt-out of future notices, please call Asaar Medical at 1-561-210-1441, TTY 711.

2. RETURN

Return this form to our practice or mail to:

Healthcare Processing Center
9450 SW Gemini Dr PMB 13762
Beaverton, OR 97008-9814

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits. This form is not valid unless it includes both a signature and date.