DATE_____
LOCATION_____

MEDICARE F.Y.I.
PEER EDUCATOR REFERRAL FORM

CLIENT NAME_____PHONE_____

STREET ADDRESS_____

CITY_____STATE_____COUNTY_____ZIP_____

DESCRIPTION OF COMPLAINT:

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CLIENT AGREEMENT

To the best of my knowledge, the above information is true and accurate, and is provided in a good faith effort to resolve a problem associated with my Medicare/Medicaid bill. I consent to the disclosure of such information solely for the purposes of investigating the above complaint. I understand the above complaint will be referred to trained volunteers, acting in good faith, providing information and assistance in resolving problems associated with Medicare and Medicaid services and the accompanying bills. I understand that a Health Insurance Counselor will contact me for further inquiry, and if warranted, the matter may be referred to appropriate regulatory and enforcement agencies for further investigation. At all times, however, the information provided will remain confidential.

Client Signature_____Date_____

Volunteer Signature_____ Date_____