DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1230
Expires: 04/24

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number

1EG4-TE5-MK73

2. Do you wish to sign up for Medicare Part B (Medical Insurance)? ☑ YES

3. Your Name (Last Name, First Name, Middle Name)

Parker, Peter, Harry

4. Mailing Address (Number and Street, P.O. Box, or Route)

3848 Overland Ave,

5. City

Culver City

State: CA

Zip Code: 90232

6. Phone Number (including area code)

(310) 204 – 4345

7. Written Signature (DO NOT PRINT)

SIGN HERE Peter parker

8. Date Signed

02 / 22 / 2023

IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

9. Signature of Witness

MM

10. Date Signed

02 / 22 / 2023

11. Address of Witness

2911, Elm Ave, Manhattan Beach, California, 90266

12. Remarks

I have heart and lung disease. Please help me.