caremore MEDICAL SUPPLY

Assignment of Benefits (AOB) & Medical Release

Patient Information

Name: _____

DOB: _____ ❑ Male ❑ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Medical Professionals/Representatives

Name: _____

Phone: _____

Fax: _____

Contact: _____

Email: _____

Primary Insurance

❑ Medicare ❑ Medicaid ❑ Private Pay

❑ Other Insurance: _____

Member ID/Policy #: _____

Secondary Insurance

Plan Name: _____

Member ID: _____

Authenticity Statement, Assignment of Benefit & Medical Release

- I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE AND AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM TO ANY INSURANCE COMPANY, ADJUSTER, CASE MANAGER OR ATTORNEY INVOLVED IN THIS CLAIM. I REQUEST PAYMENTS OF GOVERNMENT BENEFITS TO MYSELF OR TO CAREMORE MEDICAL .. IF ASSIGNMENT IS ACCEPTED. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO CAREMORE MEDICAL .. I AUTHORIZE THIS FACILITY TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF. I PERMIT A PHOTOCOPY OF THIS ASSIGNMENT/AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THAT I AM FULLY RESPONSIBLE TO CAREMORE MEDICAL . FOR ANY BALANCE NOT COVERED BY INSURANCE. I AM AWARE OF MY RIGHTS TO PROTECT MY PRIVACY AND THESE RIGHTS ARE WAIVED FOR THE PURPOSE OF CAREMORE MEDICAL SUPPLY TO CALL ME. BY CALLING, I AM GIVING MY PERMISSION FOR MY DOCTOR TO BE CALLED, FAXED, & RECEIVE FOLLOW UP CALLS AT ANY POINT BEFORE OR AFTER I RECEVIE MY SHIPMENT. I CONSENT TO RECEIEVE INFORMATION ON PRODUCTS NOT LIMITED TO SPINAL SUPPORT BRACES ON THIS PHONE CALL OR SUBSEQUENT PHONE CALLS UNTIL SUCH A POINT I INDICATE NOT TO DO SO. ALL ORDERS ARE SUBJECT TO DOCTOR APPROVAL FOR MEDICAL NECESSITY AND MAY DIFFER FROM THE PRODUCT SHOWN. SERVICES WILL BE CONDUCTED BY US CAREMORE MEDICAL SUPPLY.

- SIGNATURE ON FILE: I AUTHORIZE CAREMORE MEDICAL . TO USE THE PHRASE "SIGNATURE ON FILE " ON ANY CLAIM FORMS OR CREDIT CARD SLIPS IN ORDER TO PROCESS AND OR PAY FOR SERVICES RENDERED. MY SIGNATURE ON FILE REMAINS EFFECTIVE UNTIL REVOKED BY ME IN WRITING, HOWEVER I UNDERSTAND I AM STILL RESPONSIBLE FOR ANY UNPAID BALANCES, INTEREST CHARGES AND COLLECTION FEES. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND ITS NATURE AND EFFECT. NO REFUNDS OR RETURNS ON CUSTOM MADE OR CUSTOM FIT DEVICES OR ANY DEVICE WORN OUT OF PLACE OF SERVICE (SEE WARRANTY AND SUPPLIER STANDARDS POLICY). THE COMPANY'S PRIVACY POLICY HAS BEEN MADE AVAILABLE TO ME.

Sticker	Sticker	Sticker
L-Codes/E-Codes: _____	L-Codes/E-Codes: _____	L-Codes/E-Codes: _____

ADDITIONAL INSTRUCTIONS: The following has been given and discussed to the patient/caregiver:		
☐ Rights & Responsibilities	☐ Patient Plan of Care	☐ Cleaning, Use & Maintenance of Equipment
☐ Privacy Notice	☐ Warranty / Manufacturer Documentation	☐ Scope of Services

The products and/or services provided to you by Caremore Medical Supply, Inc. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

X _____ Date: _____ / _____ / _____

Patient / Caregiver / Power of Attorney Signature

_____ Relationship to Patient: ❑ Caregiver ❑ POA ❑Relative

Print Name ***(If other than patient & mark relationship to patient)***

Fax completed, signed form to (917) 809-7079. Any questions please call us at (917) 809-9090. Thank you.