

Patient Release of Information and Authorization of Benefits

In order for American Diabetic Supply, Inc. to send your supplies to you and to receive reimbursement directly from your insurer, **you must complete, sign and date this form** and return it to us in the enclosed postage paid envelope. Please contact us if you should have any questions. REP _____

Patient Name _____ Phone including area code _____

Address _____ Date of Birth _____

City, St, Zip _____ Social Security number _____

Physician Name _____ Physician phone _____

Physician address _____ Physician fax _____

City, St, Zip _____ Physician NPI _____

Primary Insurance _____ Policy number _____

Secondary Insurance _____ Policy number _____

I, (name) _____ hereby authorize the holder of medical or other information about me to release to the CMS, its intermediaries or to any third party payer, as required, any information needed for this or a related health claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

I also authorize release of medical information to my physician(s), and other health care providers involved in my care to assist in my treatment and auditors authorized by the organization for the purpose of certification, licensure or accreditation.

Assignment of Insurance Benefits: I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered services rendered by the organization to the organization and authorize the organization to submit claims to Medicare, Medicaid, and/or commercial insurance carriers for payment. I authorize payment of my insurance benefits directly to the organization, which payment will not exceed the balance due on my account. **I hereby guarantee payment to the organization of any and all charges not covered by this assignment, and waive any and all notices and demands in the event of non-payment there under.**

I am aware that the organization will bill me for my deductible and co-pay charges on equipment and/or supplies that I have received for payment. I will notify American Diabetic Supply, Inc. promptly of any changes that will effect insurance reimbursement. I have been trained by my physician and/or caregiver and/or supplier in the proper operation of the glucometer, test strips and lancing device.

I am not currently a member of an HMO.

I am not receiving supplies from another diabetic supply company.

You may contact my physician to acquire any needed physician orders or renewals.

I will reorder supplies only when my current supplies are nearly exhausted.

My signature below indicates receipt of my Patient Bill of Rights and Responsibilities, Medicare Supplier Standards, HIPPA Privacy Notice and Warranty Information.

Customer Signature _____ Date _____

By Representative (signature) _____ Relationship _____

Representative's Address _____ Reason for representative _____