

ASSIGNMENT OF BENEFITS

PROVIDER INFORMATION		
L.I. SCRIPT, LLC		
333 CROSSWAYS PARK DRIVE		
Phone: (631) 312 – 3850	Fax: (631) 321 – 3899	Email: billing@liscript.com

Resident Information			
Name:	Phone No.		
Address:	City:	State:	Zip Code:
Social Security Number:	Date of Birth:		

The Resident, Designated Representative and/or Sponsor understand that the fees for pharmacy services provided by LI Script, LLC may not be covered by or may exceed the Resident’s third-party insurance plan benefits. The Resident, Designated Representative and/or Sponsor understand that the Resident, Designated Representative and/or Sponsor is financially responsible to LI Script, LLC for the costs associated with the services it provides that are not covered by a third-party payor. The Resident, Designated Representative and/or Sponsor hereby assigns my benefits payable for these services to LI Script, LLC and authorize payment directly to LI Script, LLC.

The Resident, Designated Representative and/or Sponsor hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information about me as it may relate to a claim for such services to release such information to insurance company / third-party payor and to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. A photocopy of this signed authorization shall be as valid as the original.

Signature: _____

Date: _____

Print Name: _____

Date: _____

Witness: _____

Date: _____