Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below, authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Health Depot Pharmacies, LLC - DME for medical supplies and/or medical equipment furnished to me by Health Depot Pharmacies, LLC - DME.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Health Depot Pharmacies, LLC - DME to obtain medical or other information necessary, in order to, process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medical equipment provided.

5. Health Depot Pharmacies, LLC - DME to contact me by telephone or mail regarding my medical supplies and/or medical equipment order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # ( )

SIGN YOUR NAME HERE | **TODAY'S DATE** / /

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Health Depot Pharmacies, LLC - DME for any medical supplies and/or medical equipment furnished to me by Health Depot Pharmacies, LLC - DME. I authorize any holder of medical information about me to release to Health Depot Pharmacies, LLC - DME, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. **I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.**

YOUR MEDICARE # ☐☐☐-☐☐-☐☐☐☐-☐

Insurer _____ **Policy #** _____
(other than or in addition to Medicare)

Insurer Phone # ( ) _____

Please correct any errors in your name and address below.