Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

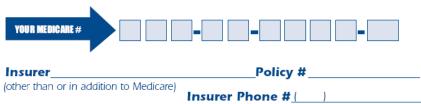
My signature and date in the box below, authorizes each of the following:

- 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.



Please correct any errors in your name and address below.