



ASSIGNMENT OF BENEFITS (AOB)

Please fax completed, signed form to U-Med Inc. at (888) 469-1150.

U-Med Inc.
3550 S. Inca St.
Englewood, CO 80110
tel: 303-548-9890 fax: 888-469-1150
email: jbambur@u-medinc.com

INSURANCE COMPANY (PRIMARY)
POLICY (Member ID and Group ID)
PRIMARY TELEPHONE

SECONDARY INSURANCE
POLICY (Member ID and Group ID)
SECONDARY TELEPHONE

- In order for U-Med Inc. to bill Medicare, Medicaid, and/or your private insurance for your medical supplies, this form must be completed and signed. We are a Medicare assignment company and will bill secondary insurance for copayments and deductibles.
- I authorize assignment of Medicare, Medicaid, and/or other insurance benefits to U-Med Inc. for DME and/or other medical supplies.
- I authorize direct billing to Medicare, Medicaid, and/or other insurance companies.
- I authorize release of my medical information to Medicare, the health care financing administration, its agents, assignees, and/or my insurance company.
- I authorize permission for U-Med Inc. to obtain any information necessary in order to process my claim(s) and contact me by phone or mail regarding my medical supply order or other medical items.
- I authorize acknowledgement that any medical reimbursement checks belonging to U-Med Inc. for supplies mailed to the client from insurance companies will be endorsed and forwarded to U-Med Inc.

Patient Name:	
Date of Birth:	
Email address:	
Address:	
City/State/Zip:	
Telephone:	
Date of Injury:	

Effective ____/____/____, _____ (current supplier) no longer has my authorization to ship any medical supplies or to bill on my behalf as my medical supply provider because I am canceling the service to begin using U-Med Inc.

Client Signature: _____ **Date:** _____

(If minor, guardian signature required. Print guardian name: _____)