ASSIGNMENT OF BENEFITS (AOB)

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

U-Med Inc. 3609 S. Wadsworth Blvd. Suite 140  
Lakewood, CO 80235  
tel: 303-548-9890 fax: 888-469-1150  
email: [sbambur@u-medinc.com](mailto:jbambur@u-medinc.com)

| **INSURANCE COMPANY (PRIMARY)** |  | **SECONDARY INSURANCE** |
| --- | --- | --- |
|  |  |  |
| **POLICY (Member ID and Group ID)** |  | **POLICY (Member ID and Group ID)** |
|  |  |  |
| **PRIMARY TELEPHONE** |  | **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, Medigap, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)