

First Class Medical Equipment and Supply, Inc.

55 Lyerly Street, Suite 300 Houston, TX 77022

Tel: 713-696-9363 Fax: 713-696-9321

ASSIGNMENT OF BENEFITS & AUTHORIZATION OF BILLING

In order for us to bill Medicare and/or other insurance for your medical supplies, equipment and/or services, this form must be completed, signed and returned immediately. Without the signed form on file, we cannot send you the product(s) you ordered.

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

- (a) Assignment of Medicare, Medicaid, Medicare Supplemental and/or other insurance benefits to First Class Medical Equipment and Supply, Inc., for all medical supplies, equipment(s) and/or service(s) furnished to me by First Class Medical Equipment and Supply, Inc.
- (b) Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
- (c) Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.
- (d) First Class Medical Equipment and Supply, Inc. to obtain any medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies, equipment(s) and/or service (s) provided.
- (e) I authorize any holder of medical information about me to release to First Class Medical Equipment and Supply, Inc., 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.
- (f) First Class Medical Equipment and Supply, Inc. to contact me by telephone or mail regarding my medical supplies, equipment(s) and/or service(s) order.

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

Please Complete the following Information:

YOUR NAME: _____ **DOB:** / /
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
TELEPHONE #: _____

PRIMARY INSURANCE NAME: _____ **POLICY OR ID #** _____ **GROUP#** _____
OTHER INSURANCE NAME: _____ **POLICY OR ID #** _____ **GROUP#** _____
(Other than or in addition to Medicare or Primary Insurance)

SIGN YOUR NAME: **DATE:**

PLEASE MAIL TO OUR OFFICE OR FAX TO: 713-696-9321