Updated Annually

Please sign & return

Assignment of Benefits and Medical Release

My signature, or a representative able to sign on my behalf, and date below authorizes and acknowledges:

- Direct Medical Incorporated to provide product to me for my use as directed by a prescribing physician or nurse practitioner.
- I was given a choice of providers to use and chose to use Direct Medical Incorporated.
- Direct Medical Incorporated to direct bill Medicare, Medicaid, or any other insurance on my behalf.
- Gives my permission to Direct Medical Incorporated to obtain pertinent documentation from my medical records from the facility, hospital or other care provider which pertains to the reasons in which I am seeking supplies.
- I understand that the information I release to Direct Medical Incorporated will be protected by Direct Medical Incorporated as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Acknowledges that I have received a copy of the 30 Medicare Supplier Standards, HIPAA Privacy Policy, Method to File a Complaint, and Hours of Operation.
- Acknowledges that I am financially responsible for any supplies not covered by my insurance as well as any co-payments, co-insurance, and deductibles.
- Acknowledges that if I am unable to pay amount due do to financial hardship that I, or someone on my behalf, contact Direct Medical Incorporated to make arrangements based on my current financial situation.
- I hereby attest that I have provided all insurance coverage applicable for supplies received at this time. In the event I change insurance companies without notifying Direct Medical Incorporated, I understand that the balance will be my responsibility.

Patient Name ____Date of Birth _______________

Patient signature ____Date______________________

If the patient resides in a Long Term Care Facility: In the event the patient is unable to sign, Medicare states that a staff member at the Long Term Care facility may sign on the patient's behalf.

Representative signature____Date_____________________

Reason patient unable to sign____