CONFIDENCE FIRST MEDICAL SUPPLIES

ASSIGNMENT OF BENEFITS (AOB)

Please complete the below AOB form which allows Confidence First Medical Supplies to bill your insurance carrier directly on your behalf.

Printed Name of Patient: _____

Patient's DOB: _____/_____/_____

Type of Equipment: _____

Assignment of Insurance Benefits: I authorize direct payment to Confidence First Medical Supplies of any insurance benefits, including Medicare, otherwise payable to me for products and services provided by Confidence First Medical Supplies also authorize my insurance company(ies) to furnish an agent of Confidence First Medical Supplies any and all information pertaining to my insurance benefits and status of claims submitted by Confidence First Medical Supplies for services rendered. I further authorize Confidence First Medical Supplies to release to my insurance company (or HCFA and its agents) any and all information pertaining to me for benefit determination. I understand that I am responsible for all deductibles, co-pays or ineligible services as stated by my insurance company.

Signature: _____

Date Signed: _____/_____/_____

Printed Name: _____
(If other than Patient)

Relationship to Patient: _____

Reason Patient Cannot Sign: _____

This form may be completed by the patient or someone acting on the patient's behalf (ex: a legal guardian, representative payee, relative, friend, representative of an institution providing the patient care or support, or of a governmental agency providing assistance)