Assignment of Benefits (AOB)

This AOB is required to bill Medicare on your behalf
This form must be signed, completed and returned before
Your order can be fulfilled.

My signature below authorizes each of the following:

1) **Assignment of Medicare, Medicaid, Medicare supplement and/or other insurance benefits to Lenox Medical for Medical Supplies furnished to me by Lenox Medical**

2) **Direct billing to Medicare, Medicaid, Medicare supplement and/or other insurers**

3) **Release of my medical information to Medicare, Medicaid and other insurers and their agents**

4) **Lenox Medical to obtain medical and other information necessary to process my claims, including determining eligibility and seeking reimbursement for medical supplies provided**

5) **Lenox Medical to contact me by telephone or mail regarding my medical supplies.**

I request that payment of Medicare, Medicaid, Medicare supplement or other insurance benefits be made on my behalf to Lenox medical supply.

I authorize any holder of medical information to release to Lenox Medical, my physician, CMS, caregiver, its agents and to my primary and other medical insurer

I agree that I am responsible for all amounts not covered by Medicare and/ or my insurer for which I am responsible including but not limited to any unmet portion of Medicare's annual deductible.

Print Name:_____ **Signature:**_____

Telephone #:_____ **Date:**_____

Medicare #:_____