

Medicare Beneficiaries
Assignment of Benefits

Once the deductible is met, Medicare pays 80% of the remaining reasonable charges

I understand that Medicare pays for 80% of the allowable charges and that I am responsible for all remaining balances not covered by Medicare. I certify that the information provided in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of any information needed to act on this request. I request that the payment of authorized benefits be made directly to the provider – [provider name here] (Tax ID—XXX) on my behalf.

Client's Signature _____ Date _____

Witness (if needed) _____

Mother/Guardian Signature _____ Date _____

Father/Guardian Signature _____ Date _____

*Please note the insured parent signature is required

Assignment of Benefits

In order for us to bill Medicaid and/or other insurance for your medical supply(s), this form must be completed, signed and returned immediately.

- I, the undersigned, hereby authorize assignments of and direct billing to Medicaid and/or other insurance benefits to [name of company] for supplies furnished to me.
- I further agree and acknowledge that my signature on this document authorizes [name of company] to obtain and release any medical and billing information to Medicaid and/or other insurers necessary to process my claim(s), including determining eligibility and seeking reimbursement for supplies provided.
- I request that payment of authorized benefits be made to [name of company] on my behalf, for supplies furnished to me.
- I will be responsible for my insurance deductible.
- If my insurance company reimburses me directly instead of [name of company], I will submit payment in the same amount to them.

Print Patient's Name

Patient's Signature

Guardian Signature

Date
