AuBurn Pharmacy Assignment of Benefits

This form is required to bill on your behalf!

Patient Name _____ **DOB** _____

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

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to AuBurn Pharmacy and/or any of our corporate affiliates for medical supplies and/or medication(s) furnished to me by AuBurn Pharmacy.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. AuBurn Pharmacy and/or any of our corporate affiliates to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. AuBurn Pharmacy and/or any of our corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

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

_____ _____

Signature of Patient / Authorized Representative **Date**

If patient cannot sign, the following **MUST** be filled out:

Authorized Representative Printed Name _____

Relationship _____ Contact Number _____

Why Patient cannot sign _____