IMPORTANT!
Please complete, sign and return this form today!

PO Box 446 ~ Stuart, FL ~ 34995-0446
Ph: 1-888-796-4733 ~ Fax: 800-755-0843

Assignment of Benefits / Medical Information Release
MEDICAL SUPPLIES

In order for us to bill Medicare and/or other insurance for your covered Medical supplies, you must complete, sign, and return this form immediately.

My signature on the line below authorizes any or all of the following:

The Assignment of Medicare, Medicaid or insurance benefits to Liberator Medical Supply, Inc. for all covered testing and medical supplies. For direct billing to Medicare, Medigap or other insurer(s), and for release of my medical information to Medicare, the Health Care Financing Administration, its agents, assigns and my insurance company. I also understand that I am responsible for and agree to pay any co-payments, deductibles, and all amounts not covered by Medicare or other insurance, **except when Medicare has denied payment for a covered item and Liberator Medical Supply has accepted assignment on that item and a specific waiver for that item has not been signed.** I will allow Liberator Medical Supply to obtain any information necessary in order to process my claim(s) and to contact me by phone or mail regarding my order or other medical items.

Please provide the information below:

Insurance Policy Info	Insurance Provider	Insured
Primary Ins:		
Secondary Ins:		
Tertiary Ins:		

Signature: ________________________________ **Date:** ___/___/______

Name: ______________________________
Address: ______________________________ Phone: ______________________
City: ______________________________
State/Zip: ______________________________

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