



IMPORTANT!



Please complete, sign and return this form today!

Permission to File Medicare and Insurance Claims

This form will only become effective in the event an order is placed for goods or services billed directly to Medicare or Insurance.

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

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 insurance(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.

I will allow Liberator Medical to obtain any information necessary in order to process my claim(s) and to contact me by mail regarding my order or other medical items.

Your Name: _____



Sign Here: X _____ **Date** _____

Medicare #: _____ Date of Birth _____

Daytime Phone: (_____) _____ - _____

Alternate Insurance Information:

Insurer: _____

Policy#: _____

Liberator Medical Supply, Inc.

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Fax: 1-800-755-0843