**AOB FORM**

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|---|
| **Print Name:** |
| **Date of Birth:** |
| **Phone Number:** |

# AUTHORIZATION FOR RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND DEDUCTIBLE/CO-PAY RESPONSIBILITY

## Release of Information

I hereby authorize the holder of medical or other information about me to release to HME Home Medical (HME), the Social Security Administration, CMS, its fiscal intermediaries, or to any third party payer, as required, any information needed for this or a related health claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.
I also authorize release of medical information to auditors authorized by HME for the purpose of certification, licensure or accreditation and to the following individuals who may be involved in assisting in the process.

_____ **__Lifetime __Until I revoke**

**Name of party or parties authorized to release information to**

☐ I authorize HME to contact me via email at: _____

☐ I authorize HME to leave messages on my phone/voicemail at: _____

## Assignment of Insurance Benefits

_x_ I certify all the information given by me is correct. I request that payment of authorized benefits be made to HME on my behalf. I assign the benefits payable for equipment, products and/or services rendered by HME to HME and authorize HME to submit claims to Medicare, Medicaid, and/or commercial insurance carriers for payment. I authorize payment of my insurance benefits directly to HME. I am aware that HME will bill me for my deductible and/or co-pay charges on the equipment and/or supplies that I have or will receive. In the event that my insurer pays me directly, I agree to forward all payments to HME, 2021 Riverside Drive, Green Bay, WI 54301. **I hereby guarantee payment to HME of any and all charges not covered by insurance.**

## Non-Assigned/Courtesy Billed Claim

__ I certify all the information given by me is correct. I authorize HME to submit claims to Medicare, and/or commercial insurance carriers for payment on my behalf. I understand that payment of my insurance benefits will be made directly to me. I understand that I am financially responsible for the entire charge that HME will bill me. **I hereby guarantee payment to HME of any and all charges for these items.**

HME Home Medical Customer Information Folder: Yes x No ☐

- Patient Rights and Responsibilities form
- Complaint Process Information
- Notice of Privacy Practices form
- Advanced Directive Information
- Supplier Standards

Warranty Policy Yes x No ☐
Instruction/Orientation completed Yes ☐ No ☐

**Electric Breast Pump**
Equipment and/or Supplies

**I hereby certify that I have read or have had this document read to me, and that I understand its contents and intents, and with my signature so execute my permission, effective as dated.**

_____ _____
Patient's Signature Date

_____ _____
Attendant Signature (If patient unable to sign) Relationship

_____ _____
Attendant Address Reason Patient unable to sign

_____
HME Representative's Name

Send To-
E-Mail: supplies@gohme.com
Fax: 920-465-3003
Mailing Address: HME Home Medical. 2021 Riverside Dr., Green Bay, WI 54301-Attention: Customer Service
____Copy given to Customer (Form – AOB – 8-7-14)