



P.O. Box 707

Mount Pleasant, SC 29465

Ph: (888) 854-0888

Fax: (888) 649-5810

Dear Patient,

Please sign and return the enclosed **Assignment of Benefits**.

THE FOLLOWING IS NOT A BILL, it is a form we need to have on file for insurance purposes.

Assignment of Benefits (AOB):

I request that all payments from any insurance carrier, including Medicare, Medicaid or private insurance company be made on my behalf to Brock Medical for any equipment, supplies, or services provided to me by Brock Medical. I authorize any holder of medical information about me to release to Brock Medical, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer. I authorize Brock Medical to contact me by phone or mail regarding my medical supplies. This authorization will remain in effect until written notification by myself or my legal representative has been received. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments, co-insurances and/or deductibles for which I am responsible. *Medicare beneficiaries, please be advised that Medicare covers supplies at 80%.*

I have also received a copy of the following:

- | | | |
|---|--|----------------------------|
| 1. Medicare Supplier Standards | 4. Patient Rights and Responsibilities | 7. Wound Care Instructions |
| 2. Notice Of Privacy Practices | 5. Hours of Operation | 8. Return Policy |
| 3. Suggestions and Complaint Procedures | 6. Warranty Information | |

I have read, received or been instructed in detail on the items above.

Please sign and mail back in the pre-paid envelope. Thank you.

Patient Name: _____

Patient Signature: _____ Date: _____

***If the patient is unable to sign: Authorized Person

Name: _____

Signature: _____

Reason Patient Cannot Sign: _____

Address of Authorized Person: _____

Relationship to Patient: _____