MEDICARE PATIENT CONSENT / ASSIGNMENT OF BENEFITS FORM

Healthy Living Medical Supply
2111 Woodward Ave STE 1100, Detroit, MI 48201
To Order, Please Call: 1-866-779-8512

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT / ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare and/or private insurance benefits to me or on my behalf be made to Healthy Living Medical Supply for any services furnished to me by Healthy Living Medical Supply. I authorize any holder of medical or other information about me to release to Medicare and/or my private insurance, and its agents, any information needed to determine these benefits for related services. I understand that Healthy Living Medical Supply reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and/or any other medical insurance companies. If applicable, I was made aware that Medicare requires the insulin pump to rent for 13 months and if there are any changes in that timeframe I must notify Healthy Living Medical Supply. In the event medical necessity no longer exists or my payer no longer deems my supplies to be covered, I understand I will be held responsible for payment and/or agree to return supplies within 45 days to Healthy Living Medical Supply. 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. I acknowledge I must call before returning any equipment or supplies that are unopened and are not past the expiration date. I acknowledge receipt and understanding of my Patient/Client Bill of Rights, Medicare DMEPOS Supplier Standards, and Notice of Privacy Practices, Complaint/Grievance Process, contact information, Advance Directives and Emergency Planning for the Home Care Patient that I received in my Welcome Packet as part of my supply order and understand that I may also view a copy of these documents at www.healthylivingmedicalsupply.com. I acknowledge receipt of any applicable product warranties. I also acknowledge that I have received and/or will receive training on the use of all products I order from Healthy Living Medical Supply. In addition, I agree that Healthy Living Medical Supply may contact me in the future, via telephone, email, mail or other means of communication, regarding ordering medical supplies.

Patient's Signature _____ Date _____
Patient's Name (Print)_____ Phone #_____
MEDICARE Number _____ Date of Birth _____
Other / Additional Insurance Name _____
Policy Number _____

Note: If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In addition, the representative's signature, date signed, representative's name (print), address, relationship to the patient and reason why the patient cannot sign must be listed below.

Representative's Signature _____ Date: _____
Representative's Name (Print) _____
Address _____
Relationship _____
Reason Patient Cannot Sign _____

Please mail this completed form, not a copy, within 5 days of receipt to the address above or fax to 866-779-8511.