



SUBMIT FORM AS FOLLOWS:
Fax Toll free at line 1-866-784-9411

Mail: ATTN: Order Department
American HomePatient
PO Box 1717
Mango, FL 33550-9910

Assignment of Benefits Diabetic Testing Supplies

Patient Name: _____

Street Address: _____

City: State: Zip: _____

Phone: (____) _____ Email address: _____

Thank you for your interest in receiving **DIABETIC SUPPLIES** from American HomePatient. We are pleased to serve as your provider of choice for home medical equipment and supplies.

We will mail your order to you as soon as we receive this form, signed and dated as long as we have received the order from your doctor and any other information or records needed for this order.

I attest the above information is correct. I authorize the direct billing to Medicare, Medicaid, Medicare Supplemental, and/or private health insurance on my behalf by American HomePatient and/or its corporate affiliates, agents, and assigns. If signed by someone other than the patient, I acknowledge I have the authority to sign on behalf of the patient.

Patient's Signature

Patient's Name Print

Date

If someone other than the patient is signing this form, please complete the following information for the person signing this form:

Print Patient's Name

Legal Representative Signature

Legal Representative PRINT NAME

Date

Relationship to patient

Reason why the patient is not able to sign

Street Address _____

City: State: Zip: _____

Phone: (____) _____