



Please complete this form and fax it to our dedicated line 1-866-784-9411,

or mail it to: ATTN: Order Department
American HomePatient
PO Box 1717
Mango, FL 33550-9910

Diabetic Testing Supplies Assignment of Benefits

Customer Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Email address: _____

Primary Insurance Name: _____ Secondary Insurance Name: _____

Date you last received diabetic supplies: _____ Supplier Name: _____

Thank you for your interest in receiving your diabetes testing supplies (including glucose meter, test strips, lancets, lancing device, and control solution) through American HomePatient. We are honored to serve as your provider of choice for home medical equipment and supplies, Our insurance experts conveniently submit all claims for you to ensure appropriate coverage of the products and services we provide. Please sign this Assignment of Benefits (AOB) form so that we may submit your claims to Medicare and your private health insurance provider.

1. I understand that signing this form authorizes American HomePatient, Inc. to submit claims on my behalf directly to Medicare and my private health insurance provider. American HomePatient will accept assignment of these benefits. This means that American HomePatient will receive direct payment for the supplies and services provided.
2. I also understand that signing this form authorizes the release of medical or other information to the Centers for Medicare & Medicaid Services, my health insurance provider, American HomePatient, Inc., and the affiliates of American HomePatient, Inc.
3. I further understand that I must return this signed AOB form to American HomePatient in order for American HomePatient to continue to provide me with diabetic products and services. If I choose not to sign and return this form, American HomePatient will not be able to continue to provide me with diabetic products and services.

Signature Date:

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

Relationship to beneficiary: _____ Phone:(_____) _____ - _____

Street address of person signing: _____

City: _____ State: _____ Zip: _____

Reason why beneficiary cannot sign this form: _____

By signing on behalf of the customer, I acknowledge that I have the authority to do so.



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