ASSIGNMENT OF BENEFITS FORM

Name of Insured (print):_____

Social Security Number:_____

I request that payment of authorized insurance benefits, including Medicare, If I am a Medicare beneficiary, be made on my behalf to First Coast Wound Care, LLC for any medical services provided to me by that organization or any of its affiliated medical providers.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company received the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained for all payment for products and services received.

_____

Patient Name(Printed)

_____

Relationship to Insured.

_____

Signature of Insured/Parent/Guardian

_____

Date