Assignment of Benefits

This form is required to bill on your behalf.

Please remember to sign, date, and return immediately.

My signature and date in the box below authorizes each of the following:

1. I authorize **T&T MEDICAL SUPPLIES, INC.** to directly bill Medicare, Medicaid, Medicare Supplemental, or other insurer(s) on my behalf, for medical supplies and/or medications furnished to me by **T&T MEDICAL SUPPLIES, INC.** and assign my rights to benefits from such insurers to **T&T MEDICAL SUPPLIES, INC.**

2. I authorize any holder of medical information about me to release to **T&T MEDICAL SUPPLIES, INC.**, my physician(s), caregiver, CMS, its agents and to primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services.

3. **T&T MEDICAL SUPPLIES, INC.** to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

4. I have received the following information: Medicare Supplier Standards, Notice of Privacy Practices, Patient Rights & Responsibilities, Complaint Reporting Information, and Warranty Information.

SIGN YOUR NAME HERE → ____________________ TODAY'S DATE → __________

By signing this form, you are authorizing **T&T MEDICAL SUPPLIES, INC.** to contact you by telephone.

Month/Day/Year

Your Phone Number: (_____)________________________________

Your Medicare Number: [| |] - [|] - [| | |] - [ ]

Your Email: ____

Your Insurer ______________________________ **Policy #** ____________________

(Other than or in addition to Medicare)

Insurer Phone # (______)________________________________

Name: ____

Address: ____

City: ______________________ **State:** __________ **Zip:** __________