Korman Healthcare
5783 West Erie St.
Chandler, AZ 85226
800-306-8641

Assignment of Benefits Form

Beneficiary Name (print)

Beneficiary Address (print)

1 **My signature below authorizes the following:**
Statement to permit payment of insurance benefits to provider, physician and patient.

I request that payment of authorized Medicare and/or private insurance benefits be made on my behalf to Korman Healthcare for any services furnished to me in connection with Korman Healthcare. I authorize any holder of medical or other information about me to release to and/or receive from the Centers for Medicare and Medicaid Services and/or my private insurance, and its agents, any information needed to determine these benefits for related services.

I understand that Korman Healthcare 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.

I agree to assume responsibility for payment for services and/or products furnished to me by Korman Healthcare which are not paid to Korman Healthcare for any reason by Medicare and/or any other medical insurance.

I have received and understand my Medicare DMEPOS Supplier Standards and Notice of Privacy Practices. In addition, I agree that Korman Healthcare may contact me in the future, via telephone or other means of communication, regarding ordering medical supplies.

Beneficiary's Signature _____ **Date** ___/___/___

Complete below only if patient is unable to sign:

If the beneficiary is physically or mentally unable to sign, a representative may sign on the beneficiary's behalf. If you are signing on behalf of the patient, please include the appropriate documentation, such as a power of attorney. In addition, the representative's signature, date signed, representative's name (print), address, relationship to the beneficiary and reason why the beneficiary cannot sign must be listed below.

Representative's Signature	Date	Representative's Name (Print)

Street Address	City	State	Zip

Relationship	Reason Beneficiary Cannot Sign