Home Care Delivered™
A Medical Supply Company

HCD6103

Important!

You must return this *signed* and *dated* form before we can ship your next order.
This form will allow Home Care Delivered to bill your insurance provider on your behalf.

To expedite your order, please FAX the completed form to 1-800-716-9586 (toll-free fax), SCAN AND EMAIL the form to AOB@HCD.com or use the enclosed envelope and MAIL the form to:
Home Care Delivered, Inc • PO Box 4350 • Glen Allen, VA 23058

INFORMATION BELOW MUST BE PROVIDED BY EITHER THE PATIENT OR THE PATIENT'S AUTORIZED REPRESENTATIVE

Assignment of Benefits / Medical Information Release

By signing below, I authorize that payment of my insurance benefits (Medicare, Medicare Supplement or other) be made to Home Care Delivered, Inc. for any supplies or services furnished to me by Home Care Delivered, Inc. I understand that I am responsible to pay all amounts that are not covered by my insurance. I authorize any holder of my medical information to release to Home Care Delivered, Inc. any information needed to determine benefits payable for these supplies or services. In addition, I authorize Home Care Delivered, Inc. to release my medical records to insurers as well as medical professionals. I authorize Home Care Delivered, Inc. to contact me by telephone, email or mail regarding my medical supplies.

Customer Name (please print): _____

Date of Birth: _____ / _____ / _____ (MM DD YY) Account: _____

If the patient has signed by marking an "x" due to language barriers or physical limitations, the signature and address of the witness should be entered next to the patient's mark.

Today's Date _____ / _____ / _____ (MM DD YY)

Customer's Phone # ( )

Customer's Signature

CUSTOMER REPRESENTATIVE SECTION (Complete only if customer is unable to sign above)

If the patient is unable to sign due to a physical or mental condition, an Authorized Representative of the patient must complete the section below. By signing on behalf of the patient, you acknowledge that you have authority to do so.

Date _____ / _____ / _____ (MM DD YY)

Authorized Representative's Signature _____

Authorized Representative's Name: _____

Authorized Representative's Address: _____

City: _____ State: _____ Zip: _____

Authorized Representative's Relationship to Patient: _____

What is the physical or mental reason patient is unable to sign?: _____