REQUIRED FORM - PLEASE COMPLETE AND RETURN

Assignment of Benefits Form

Thank you for your requesting your Durable Medical Equipment ("DME") products through American Medical Distribution, Inc. ("AMDI"). Our insurance experts will submit all claims for you to ensure appropriate coverage of the products we provide.

Please complete this form and use the enclosed self addressed envelope to mail to:

American Medical Distribution, Inc.
ATTN: Patient Form
7300 124th Ave N
Largo, Florida 33773

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 AMDI to submit claims on my behalf directly to Medicare and my private health insurance provider. AMDI will accept assignment of these benefits. This means that AMDI will receive direct payment for the products provided.
2. I also understand that signing this form authorizes the release of medical or other information for the following purposes: (i) release any information necessary to insurance carriers regarding my illness and treatments; (ii) process insurance claims generated in the course of examination or treatment; and (iii) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
3. I further understand that fees are due and payable on the date that products are shipped and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this Assignment is to be considered as valid as the original.
4. I further understand that I must return this signed AOB form to AMDI in order for AMDI to continue to provide me with products. If I choose not to sign and return this form, AMDI will be unable to continue to provide me with DME products.

First Name: _____ Last Name: _____ Email: _____

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone #: _____ Cell Phone # (Optional): _____

Signature: _____ Date: _____