



SUBMIT FORM AS FOLLOWS:
Fax Toll free at line 1-866-784-9411

Mail: ATTN: Order Department
American HomePatient
PO Box 1717
Mango, FL 33550-9910

Assignment of Benefits/Medical Information Release Diabetic Testing Supplies

Patient Name: _____

Street Address: _____

City: State: Zip: _____

Phone: (____) _____ Email address: _____

Thank you for your interest in receiving **DIABETIC SUPPLIES** from American HomePatient. We are pleased to serve as your provider of choice for home medical equipment and supplies.

We will mail your order to you as soon as we receive this form, signed and dated as long as we have received the order from your doctor and any other information or records needed for this order.

I attest the above information is correct. I authorize the direct billing to Medicare, Medicaid, Medicare Supplemental, and/or private health insurance on my behalf by American HomePatient and/or its corporate affiliates, agents, and assigns. If signed by someone other than the patient, I acknowledge I have the authority to sign on behalf of the patient. I have received, read and understand THE TERMS OF AGREEMENT AND AGREE TO BE BOUND BY THE TERMS OF AGREEMENT. I acknowledge receipt of the Company's Notice of Privacy Practices.

Signature of patient/legal representative:	Date:

If someone other than the patient is signing this form, please complete the following information for the person signing this form.

Relationship to patient: _____ Reason patient cannot sign: _____

Street Address of person signing: _____

City: State: Zip: _____ Phone: (____) _____

If you have any questions, please contact _____ at _____.

Employee ID
