

Release of Information & Assignment of Benefits
Commercial Insurance

I hereby authorize release of any and all medical information necessary to file a claim with my Insurance Company and assign benefits otherwise payable to me (Name) _____ to PIE* Medical International, Inc. I understand that I may be financially responsible for any balance not covered by my Insurance Company. If I become financially unable to make regular payments for balances owed I will contact PIE* Medical International, Inc. (770-447-1275) for a Resolution to work out arrangements for my obligation of payments. A Copy of my Signature shall be as valid as the Original.

Signature of Patient or Guardian: _____

Medicare

Beneficiary: _____ Medicare Number: _____

I authorize any holder of Medical and/or Other Information about me to be released to The Social Security Administration and Health Care Administration or its Intermediaries, Carriers or Providers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request payment of Medical Insurance Benefits be made either to myself or to the party who accepts Assignment. I understand it is mandatory to notify the Health Care Provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding of this information.) Regulations pertaining to Medicare assignment benefits also apply.

Signature: _____

Medicare Supplemental Insurance

I request that payments of authorized Medigap Benefits be made on my behalf to PIE* Medical International, Inc. for any services furnished to me by them. I authorize any holder of Medical Information about me to release to Medigap Insurance Carrier any information necessary to determine benefits payable for related services.

Beneficiary: _____ Medicare # _____

Medigap # _____

Beneficiary Signature: _____ Date: _____