**MP Medical Supply, LLC**
**767 Alpha Drive**
**Highland Heights, OH 44143**
**(440) 448-6005 office**
**(216) 250-8102 fax**

# AUTHORIZATION FOR RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND DEDUCTIBLE/CO-PAY RESPONSIBILITY

Customer Name _____ Insurance ID Number _____

Equipment/Service _____ Date of Service _____

**Release of Information:** I hereby authorize the holder of medical or other information about me to release to the Social Security Administration, Centers for Medicare and Medicaid Services, its intermediaries or to any third party payer, as required, any information needed for this or a related health claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

I also authorize release of medical information to my physician(s), other health care providers to assist in my treatment, auditors authorized by MP Medical Supply, LLC for the purpose of certification, licensure or accreditation and to the following individuals who may be involved in assisting in my affairs:

_____ _____

I understand that I have the right to revoke and or restrict the use of this consent by notifying MP Medical Supply, LLC in writing and that prior to signing this consent I have received and have had the opportunity to review MP Medical Supply, LLC privacy policy. I also understand that I have right to access my health information, request that MP Medical Supply, LLC amend health information, and the right to request an accounting of all disclosures of my health information.

**Assignment of Insurance Benefits:** I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered services rendered by MP Medical Supply, LLC to MP Medical Supply, LLC and authorize MP Medical Supply, LLC to submit claims to Medicare, Medicaid, and/or commercial insurance carriers for payment. I authorize payment of my insurance benefits directly to MP Medical Supply, LLC, which payment will not exceed the balance due on my account. I hereby guarantee payment to MP Medical Supply, LLC of any and all charges not covered by this assignment, and waive any and all notices and demands in the event of non-payment there under.

I have been notified by MP Medical Supply, LLC that he/she believes that, in my case, my insurance carrier likely to deny payment for the items identified below, for the reasons stated. If my insurance denies the claim I agree to be personally and fully responsible for payment. Items likely to be denied include:_____

I am aware that MP Medical Supply, LLC will bill me for my deductible and co-pay charges on equipment and/or supplies that I have rented for payment each month.

I agree the rental equipment remains the property of MP Medical Supply, LLC and will be returned in good condition when no longer necessary. I hereby certify that I have read or have had this document read to me, and I understand its contents and intents, and with my signature so execute my permission, effective as dated:

By initialing this box I certify under the penalties of perjury that I, to my best knowledge and belief, am the person represented above and authorize the billing of my insurance/Medicare/Medicaid, as well as request the shipping of the product from MP Medical Supply, LLC._____

| | |
|---|---|
| _____ | _____ |
| Customer Signature | Date |
| _____ | _____ |
| By Representative (Signature) | Date |
| _____ | _____ |
| Representative's Address | Reason Patient Unable to Sign |