

Important!

You must return this signed and dated form before we can ship your 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 **800-716-9586** (toll-free fax)
or mail the form to: Home Care Delivered, Inc • PO Box 4350 • Glen Allen, VA 23058**

Warranty and Instruction Information: Information regarding the proper use of your supplies and warranty information, if applicable, will be located inside the original manufacturer packaging. Please take the time to read this material carefully. If you have any questions or require additional instruction regarding the use of your supplies once you receive them, please contact us at 800-565-5644.

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

Patient Authorization of Billing/Medical Information Release

I request that payment of my insurance benefits (Medicare, Medicare Supplemental 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.

Patient Name: _____

Date of Birth: / /
MM DD YY

If 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 beneficiary's mark.

Patient's Signature **Today's Date**
MM / DD / YY

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

Authorized Representative's Signature: _____

Authorized Representative's Name: _____ **Today's Date**
MM / DD / YY

Authorized Representative's Address: _____

City: _____ State: _____ Zip: _____

Authorized Representative's Relationship to Patient: _____

Physical/Mental Reason patient is unable to sign: