



Home Care
Delivered, Inc.®

More than just home delivery™

ASSIGNMENT OF BENEFITS

I request that payment of my insurance benefits (Medicaid, 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 medical information about me 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 in my care and/or make said copies. I authorize **Home Care Delivered, Inc.** to contact me by telephone, e-mail or mail regarding my medical supplies.

ALL INFORMATION MUST BE PROVIDED BEFORE WE ARE ABLE TO SHIP YOUR ORDER

Supplies currently being ordered:

Diabetic Urological Wound Care Ostomy

Please note — If you are a patient with diabetes and will be receiving a diabetic meter from Home Care Delivered, please know the warranty and instructional materials for the meter are located inside the meter box. Please take the time to read this material carefully and don't hesitate to call us if you should have any questions concerning this information.

ALL INFORMATION MUST BE PROVIDED BELOW BEFORE WE ARE ABLE TO SHIP YOUR ORDER

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Signature: _____  Date: _____ / _____ / _____

*****IF PATIENT UNABLE TO SIGN, PROVIDE THE FOLLOWING *****

Authorized Representative (Name): _____

Signature: _____  Date: _____ / _____ / _____

Authorized Representative (Address): _____

City: _____ State: _____ Zip: _____

Relationship to the patient: _____

Medical reason patient is unable to sign: _____

*****PLEASE SIGN AND RETURN TO HOME CARE DELIVERED VIA MAIL OR FAX*****