Assignment of Benefits (AOB) Medical Release

Patient Information

Name: ____

DOB: ______ / ______ / ________ ❑ Male ❑ Female

Address: ____

City: ____________________ State: _____ Zip: ________

Phone: ____

Local DME Supplier *(Test Courier)*

Name: ____

Phone: ____

Fax: ____

Contact: ____

Email: ____

Primary Insurance

If Medicare/Medicaid, please check the appropriate box & enter the ID # in the space below and proceed.

❑ Medicare ❑ Medicaid ❑ Private Pay ($22.45)

❑ Other Insurance: ______________________________

Member ID/Policy #: ______________________________

Group #: ___________ Phone #: ____________________

Claims Address: ______________________________

City/State/Zip: ______________________________

Secondary Insurance

Plan Name: ______________________________

Member ID: ______________________________

Group #: ___________ Phone #: ____________________

Claims Address: ______________________________

City/State/Zip: ______________________________

Some Secondary Insurance Companies do not cover this service which the member will be responsible from the amount left from Primary Insurance. Typical co-pays/coinsurances are in the range of $5 - $15.

Medical Release

I, the undersigned, authorize ADSI (Medicare Enrolled IDTF) to release my medical record chart pertaining to this overnight oximetry test to the above named DME Supplier. Furthermore, I authorize the DME Supplier to speak with my physician about any treatment, present or future, necessary based on the overnight oximetry results provided by ADSI. By signing below I am confirming that I have read and understood this **Medical Release** and agree fully with the terms stated within.

X ____ Date: ______ / ______ / __________

Patient / Caregiver / Power of Attorney Signature

____ Relationship to Patient: ❑ Caregiver ❑ POA ❑Relative

Print Name ***(If other than patient & mark relationship to patient)***

Assignment of Benefit & Authenticity Statement

I, the undersigned, certify that I had the pulse oximeter dropped off by the DME Supplier and was provided detailed instructions by ADSI – Medicare Enrolled IDTF. Furthermore, I certify that I was the only person to test with this unit (Pulse Oximeter SN#: ______________________) and that I did not alter or attempt to tamper with the unit in any way, shape or form. I authorize the DME Supplier to transmit the oximetry data to ADSI – Medicare Enrolled IDTF to process these test results and release them to my ordering physician and DME Supplier, if Medical Release signed.

I, the undersigned, authorize and release ADSI – Medicare Enrolled IDTF to bill my primary and secondary insurance carrier(s) on my behalf for the cost of the overnight pulse oximetry. Furthermore, I authorize the payment to be made directly to ADSI for the cost of this oximetry test. I also understand that I am financially responsible for the amount that my insurance, primary or secondary, does not cover due to denial(s), co-pays, deductibles or coinsurances and will pay any bill received from ADSI promptly. In the event my insurance coverage has been terminated or I do not have insurance, I agree to pay ADSI the billed amount for this oximetry testing.

X ____ Date: ______ / ______ / __________

Patient / Caregiver / Power of Attorney Signature

____ Relationship to Patient: ❑ Caregiver ❑ POA ❑Relative

Print Name ***(If other than patient & mark relationship to patient)***

Fax completed, signed form to ADSI at (352) 274-9122. Any questions please call (352) 293-2810. Thank you.