BERNENS CONVALESCENT PHARMACY, INC
5053 GLENWAY AVENUE
CINCINNATI, OH 45238
Phone: (513) 471-7575 Fax: (513) 557-2360
After Hour: (513) 471-7575 Toll Free: (877) 471-7575

Assignment of Benefits

Name of Insured: _____

HICN/Medicare Number: _____

Equipment to be Supplied:

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made either to me or on my behalf to the organization listed above (referred to as BERNENS CONVALESCENT PHARMACY, INC) or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to BERNENS CONVALESCENT PHARMACY, INC, Center for Medicare Services (CMS), my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to BERNENS CONVALESCENT PHARMACY, INC for any charges not covered by health care benefits, including Medicare if I am a Medicare beneficiary. It is my responsibility to notify BERNENS CONVALESCENT PHARMACY, INC of any changes in my health care coverage prior to accepting delivery of any equipment. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by BERNENS CONVALESCENT PHARMACY, INC and/or my health care insurer if the submitted claims or any part of them are denied for payment due to any false information given on my part regarding my health care, coverage, or benefits.

I hereby acknowledge that I have a medical need for the equipment provided in my home. I understand that if I provide any false information to BERNENS CONVALESCENT PHARMACY, INC that results in my claim being denied, I am financially responsible for the full cost and charges of the equipment as well as the cost of all collection, including reasonable attorney's fees. I understand by signing and returning this to BERNENS CONVALESCENT PHARMACY, INC I am allowing that organization to bill my insurance company for equipment after it has been delivered to me, for payment. By not signing this I am accepting the responsibility for full payment.

A $30.00 FEE WILL BE ASSESSED TO DELIQUENT ACCOUNTS OVER 90 DAY PAST DUE.

I hereby certify that I am not receiving Hospice Care or under the care of a skilled nursing facility.

Signature of Beneficiary: _____

Print Name: _____

Date: _____