CLOCK MEDICAL SUPPLY, INC.
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD PO BOX 620 WINFIELD, KS 67156-062
PHONE: 1-620-221-0550 TOLL FREE: 1-800-362-1314 FAX: 1-620-221-7460

PLEASE SIGN AND RETURN

Assignment of Benefits / Release of Information

NAME OF INSURED (print): _____

MEDICARE #: _____

OTHER INSURANCE NAME: _____ **POLICY #:** _____

OTHER INSURANCE ADDRESS: _____

MEDICAID STATE / MCO GRP: _____ **MEDICAID / KANCARE #:** _____

☐ *Urological* ☐ *Ostomy* ☐ *Wound Care* ☐ *Diabetic* ☐ *Enteral Nutrition*

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 Clock Medical Supply, Inc. for any equipment, supplies, or services provided to me by Clock Medical.

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 Clock Medical, the Centers for Medicare and Medicaid, my insurance carrier or other medical entity.

I agree to permit Clock Medical Supply and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

A copy of this authorization will be sent to the Centers for Medicare and Medicaid, my insurance company or other entity if requested. The original authorization will be kep on file by Clock Medical Supply, Inc.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage (i.e. Home Health episodes, Hospice episodes, Hospital stays). If I fail to notify Clock Medical Supply of any of the changes, I accept financial responsibility for the supplies that were provided to me during that time period.

In addition, I acknowledge receipt of the following materials:

☐ *New Customer Handout packet*
☐ *HIPAA Privacy Notice*
☐ *Medicare Supplier Standards*
☐ *Instructions provided*

Signature of Insured or Parent/Guardian _____ **Relationship** _____

Name of person signing (print) _____ **Date** _____