Angel Medical Supply, LLC
5829 W. Sam Houston Parkway North, Ste. 1209
Houston, TX 77041 713-856-9930

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Angel Medical Supply, LLC. and/or any of our corporate affiliates for medical supplies and/or medication(s) furnished to me by Angel Medical Supply, LLC.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Angel Medical Supply, LLC and/or any of our corporate affiliates to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. Angel Medical Supply, LLC and/or any of our corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # ( )

SIGN YOUR NAME HERE | **TODAY'S DATE** / /

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to *Angel Medical Supply, LLC* and/or any of our corporate affiliates for any medical supplies and/or medications furnished to me by *Angel Medical Supply, LLC* . I authorize any holder of medical information about me to release to *Angel Medical Supply, LLC* ., my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

YOUR MEDICARE #

Insurer _____ **Policy #** _____
(other than or in addition to Medicare)

Insurer Phone # ( ) _____

Please correct any errors in your name and address below.