Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

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

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to *KPH Health Services, Inc.* and/or any of our corporate affiliates *Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc.,* for medical supplies and/or medication(s) furnished to me by *KPH, Inc.*

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. *KPH Health Services, Inc.* and/or any of our corporate affiliates *Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc.* 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. *KPH Health Services, Inc.* and/or any of our corporate affiliates *Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc.* 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.

Phone __ __ __ - __ __ __ - __ __ __ __

Sign Name Here ______________________ **Date** _______________

Print Name Here ______________________

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to KPH Health Services, Inc. and/or any of our corporate affiliates Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc. for any medical supplies and/or medications furnished to me by KPH Inc. I authorize any holder of medical information about me to release to KPH, Inc., 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
/other than *or* in addition to Medicare)

Policy#_______________

Insurer Phone#(____)_____________

Please correct *any* errors in your name *and* address below.

UPDATED July 2019

29 EAST MAIN STREET • GOUVERNEUR, NY 13642 • 315-287-3600