GENAO’S MEDICAL SUPPLY
471 NEW BRUNSWICK AVENUE PERTH AMBOY, NJ 08861
TELEPHONE: 732-324-8700 | FACSIMILE: 732-324-8702 | EMAIL: INFO@GENAODME.COM

Name:__________________________ DOB:____________________

ASSIGNMENT OF BENEFITS

I request that payment of authorized medical benefits be made to Genao’s Medical Supply for any covered services furnished to me. In Cases where Genao’s Medical Supply agrees to accept assignment, Genao’s Medical Supply will accept the charge determination as the full charge for the covered services. I am always responsible for the deductible, co-insurance and unassigned uncovered services. I agree to pay Genao’s Medical Supply any payment made directly to me by insurance for services provided by Genao’s Medical Supply on an assigned bases. I understand that Genao’s Medical Supply does not accept returned merchandise if worn, used for sanitary or hygienic purposes, or if it is disposable. All rental equipment shall remain property of Genao’s Medical Supply. It is my responsibility to inform Genao’s Medical Supply if I relocate, no longer need the equipment, or am admitted to a hospital or nursing facility. I shall also inform Genao’s Medical Supply if the equipment is not working properly. I agree that in the event my insurance or other third party payer refuses to pay the rental or purchase price of the equipment or service that I will be responsible for those payments or shall return the equipment involved. I have received, understand, and accept the Supplier Standards, HIPPA Notice, and Patient Bill of Rights & Patient Responsibilities. I have received, understand and accept the assignment of benefits, giving Genao’s Medical Supply permission to bill my insurance company, and I have NOT received any of the listed supplies from any other provider.

Patient’ or Authorized Person’s Signature.

I authorize the release of any medical or other insurance information to process this claim. I also request payment of government benefits either to me or to Genao’s Medical Supply.

Signature: _______________________________________ Date: ________________