



This is not a bill!!!

Assignment of Benefits

Please complete, sign and return this form today. Thank you!

123 Any Street
Apt 1
Anytown, US 00000

John Q Public

ID- 0000000

Primary Insurance-
Medicare

Policy Number-
123456789

Secondary Insurance-

Policy Number-

I, John Q Public, authorize the release of any medical or other information necessary, for ClearChoice to process and submit my claims to my insurer.

I also authorize payments of medical benefits to ClearChoice for services and supplies I have received from ClearChoice

I hereby certify that I have read or have had this document read to me, and I understand its contents and intents, and with my signature so execute my permission, effective as dated.

My signature also acknowledges receipt of 1) Medicare Supplier Standards including Warranty Information 2) Patient Bill of Rights and Responsibilities 3) the organization’s complaint policy and 4) the Organization’s Privacy 5) Financial Rights and Responsibilities Document

By signing below I attest that I have read and understand the above mentioned documents.

Customer Signature _____ **Date** _____

Representative Signature _____ **Relationship** _____

(This assignment does not expire and will remain in force until your account has been cancelled. You may cancel at any time.)

ClearChoice
115 Avenue L • Delray Beach, 33483
Phone: 800-400-1014 Fax: 800-284-0829



Financial Rights and Responsibilities

This document is designed to inform you of your financial rights and responsibilities as it pertains to your medical supply account with ClearChoice

- 1) You have the right to know what co-pays and/or deductibles, if any, you will be responsible for paying. Before receiving your initial order one of our customer service representatives will call you to confirm your first order and explain your financial responsibilities based on your insurance coverage.
- 2) If you cannot afford to pay your deductible and/or co-pay you can apply for our Hardship Program that will allow us to waive these fees. If you wish to apply for this program please call 800-400-1014 and speak to one of our customer service representatives. We will send you an application that has some basic financial questions that will help us determine if you qualify for the Hardship Program.
- 3) You have the right to cancel your account at any time. You can do so by calling one of our customer service representatives between 9AM – 5PM Eastern. Our toll free number is 800-400-1014
- 4) You have the right to be informed of any supplies that your insurance does not cover prior to those supplies being shipped to you. You will be informed of this in writing via an Advanced Beneficiary Notice which will explain the costs and give you the following three (3) options:
 - a) Cancel the order so you do not have to pay for the supplies.
 - b) Choose to just receive the portion of your order that is covered by your insurance.
 - c) Accept the order and agree to pay for the uncovered item.
- 5) You have the right to return unopened supplies for a refund within thirty (30) days from when you received it.
- 6) All supplies sold by ClearChoice carry the one (1) year manufacturers' warranty. If you have a problem with any of the supplies that we send you please call our customer service representatives to coordinate receiving replacement supplies at no-charge.
- 7) If you change your insurance coverage you must call and let us know so we can update our records and re-check you insurance eligibility.
- 8) You cannot have two companies sending you the same supplies such as; two (2) diabetic testing suppliers or two (2) wound care suppliers. If you receive supplies from two (2) companies your insurance will only pay for one and you will be billed for the other. So if you decide to switch companies you must inform us before you receive your next shipment otherwise you may be billed for the uncovered item.