

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!  
American Orthopaedics & Diabetic Shoes

***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 American Orthopaedics & Diabetic Shoes and/or any of our corporate affiliates for medical supplies and/or medication(s) furnished to me by American Orthopaedics & Diabetic Shoes.
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. American Orthopaedics & Diabetic Shoes and/or any of our corporate affiliates to obtain medical or other information necessary to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.
5. American Orthopaedics & Diabetic Shoes 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.**

**I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to American Orthopaedics & Diabetic Shoes and/or any of our corporate affiliates for any medical supplies and/or medications furnished to me by American Orthopaedics & Diabetic Shoes. I authorize any holder of medical information about me to release to American Orthopaedics & Diabetic Shoes, 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. I understand that custom items are non-returnable.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

American Orthopaedics & Diabetic Shoes  
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