CITIZENS PHARMACY SERVICES

ASSIGNMENT OF BENEFITS

Beneficiary Name (Please Print): _____

Phone Number: _____ Date of Birth: _____

Address: _____

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I assign the right and responsibility to CITIZENS PHARMACY SERVICES to bill on my behalf, and accept payment from Medicare and/or my private insurance for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) products and services provided to me, the Beneficiary.

I understand and agree that I am responsible to pay any deductible amount applied to the claims and the coinsurance not paid by Medicare and/or private insurance carrier. We will bill supplemental insurance if applicable for deductible and coinsurance amounts.

If, for any reason and to whatever extent, CITIZENS PHARMACY SERVICES does not receive payment from my insurer or the third-party payor that is obligated to pay for my medications/supplies, I do hereby agree to pay CITIZENS PHARMACY SERVICES directly for the unpaid balance within thirty (30) days of receipt of an invoice from CITIZENS PHARMACY SERVICES, except in cases where such payment is prohibited by applicable law.

I agree that any amounts I owe for more than thirty (30) calendar days may bear interest from the due date of such invoice, at the lesser of one and one-half percent (1.5%) per month or the maximum rate permitted by applicable law. I further agree to pay all costs and expenses of CITIZENS PHARMACY SERVICES collection efforts, including reasonable attorney's fees and court costs that are incurred by CITIZENS PHARMACY SERVICES to collect overdue amounts.

I permit CITIZENS PHARMACY SERVICES to release and collect my health information, and other information, as required (and as permitted by the HIPAA Regulations) from my health care providers and Medicare and/or private insurance company to receive payment from Medicare and/or insurance company.

I understand that this form will be maintained and made available to Medicare and/or private insurance company or its representatives.

_____ _____

Beneficiary/ Caregiver Signature Date

_____

Caregiver Printed Name (If Applicable)