# Medicare Assignment Form

P.O. Box 1244 • Winter Park, FL 32790-1244
Toll free: 866-699-8239 • **Fax 407-671-7960**
www.Xubex.com

| PATIENT INFORMATION | | | |
|---|---|---|---|
| First: | Last: | | M.I.: |
| Address: | | | |
| City: | State: | Zip: | |
| Date of Birth: | ☐ Male ☐ Female | SSN: | |
| Best Phone: | Alt. Phone: | | |
| Email: | | | |

| PRESCRIBER INFORMATION | | | |
|---|---|---|---|
| First: | Last | M.I. | |
| DEA#: | Med. Lic. #: | NPI#: | |
| Office Contact: | Phone: | Fax: | |
| Address: | City: | State: | Zip: |

| INSURANCE INFORMATION | | |
|---|---|---|
| **IMPORTANT: PLEASE INCLUDE COPY OF YOUR MEDICARE CARD.** | | |
| **Do you have Medicare?** ☐ YES ☐ NO | Medicare #: | Medicare ID#: |
| **Secondary Insurance:** | | Phone: |
| BIN #: | PCN #: | |
| Group #: | ID #: | |

| CLINICAL INFORMATION | | |
|---|---|---|
| **Primary Diagnoses:** | Diagnosis and ICD-9: | Date first diagnosed: |
| | Diagnosis and ICD-9: | Date first diagnosed: |
| Are you insulin dependent? ☐ YES ☐ NO | How many times a day do you test? | |
| Do you have a blood glucose meter? ☐ YES ☐ NO | **If so, what type?** | |

**AUTHORIZATION OF BENEFITS:**

Medicare Lifetime Authorization:

I authorize Xubex to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to Xubex who accepts assignment of any bills for services furnished to me. I understand that I will be financially responsible for my yearly Medicare deductible and 20% co-payment/insurance portion. Furthermore, I accept responsibility for any and all medical equipment/supplies while in my possession.

| PATIENT/LEGAL GAURDIAN SIGNATURE | | |
|---|---|---|
| Patient First: | Patient Last: | M.I.: |
| Guardian First: | Gaurdian Last: | Relationship to Patient: |
| **Signature:** | Date: | |

| FOR OFFICE USE ONLY: | | |
|---|---|---|
| Patient Code: | Date Received: | By: |

XUBEX® Pharmacy Services
Affordable Quality Care

# Diabetic Supply Authorization Form

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## AUTHORIZATION FOR SERVICE

The patient/legal guardian authorizes Xubex Pharmacy Services to supply diabetic supplies as requested by the patient/legal guardian and/or by prescription from physician.

## RELEASE OF MEDICAL RECORDS TO YOUR INSURANCE COMPANY

The patient/legal guardian authorizes Xubex Pharmacy Services to disclose the patient's diabetic supply records to Medicare or the insurance company.

## ASSIGNMENT OF BENEFITS

The patient/legal guardian authorizes payment directly to Xubex Pharmacy Services of any insurance or health plan benefits payable for services rendered.

## CHANGE OF INSURANCE

The patient/legal guardian agrees to immediately contact Xubex Pharmacy Services to advise of any cancellation or change in policy. The patient/legal guardian will be responsible for all charges not paid by insurance company due to cancellation of policy, changing of policy to an HMO policy or by ordering from multiple suppliers simultaneously.

## DEDUCTIBLE AND CO-PAYMENT

The patient/legal guardian understands and agrees to be responsible for payment of any unmet portion of the annual insurance/Medicare deductible that may be withheld from payment to Xubex Pharmacy Services.

**(CHECK ONE)**

☐ I understand and agree that my supplemental insurance policy or I will be responsible for paying the 20% co-payment/insurance (of insurance/Medicare allowable amounts) for my diabetic supplies.

☐ I am financially unable to pay for my co-payment/insurance amounts and have signed a Hardship Statement/Application which is attached to this document.

## RECEIPT OF MEDICARE/INSURANCE NOTIFICATION DOCUMENTS

My signature acknowledges receipt of the Medicare/Insurance Required Documents package, which consists of :

i) Medicare Supplier Standards
ii) Patient Bill of Rights and Responsibilities
iii) Xubex's Complaint Policy
iv) Xubex's Privacy Notice

| PATIENT/LEGAL GAURDIAN SIGNATURE | | |
|---|---|---|
| First: | Last: | M.I.: |
| **Signature:** | Date: | |
| **FOR OFFICE USE ONLY:** | | |
| Patient Code: | Date Received: | By: |