EXTENDED pharmacy™

ASSIGNMENT OF BENEFITS (AOB) FORM

Patient / Insured Name: _____

Date of Birth: _____

Insurance Company: _____

Policy / Member ID #: _____

Group #: _____ (if applicable)

Provider / Business Name: _____

Provider NPI / Tax ID (if applicable): _____

Assignment of Benefits Authorization

I hereby assign and authorize payment of medical / service benefits, including major medical benefits, to the provider listed above for services rendered to me or my dependent.

I authorize the provider to bill my insurance company directly and to receive payment for covered services. I understand that I am financially responsible for any charges not covered by my insurance, including deductibles, co-payments, co-insurance, and non-covered services.

I also authorize the release of medical or service-related information necessary to process insurance claims.

This assignment remains valid until revoked by me in writing.

Patient / Insured Signature: _____

Responsible Party Signature(If signing for patient):_____

Responsible Party Printed Name (If signing for patient): _____

Responsible Party Relationship to Patient:_____

Date: _____