

Assignment of Benefits (AOB) and Acknowledgment Form

Please sign this form and return using the included pre-paid envelope

THE FOLLOWING IS NOT A BILL, it is a form we need on file for compliance and insurance purposes.
Please call us with any question regarding this form.

I request that all payments from any insurance carrier including Medicare, Medicaid, or private insurance company be made on my behalf to LiveFree Medical LLC, for any equipment, supplies, or services provided to me by LiveFree Medical (LFM). I authorize any holder of medical information about me to release to LFM, my physician(s), caregiver, CMS, it's agents and to my primary and/or other medical insurer, as well as any information needed to determine or secure eligibility information and/or reimbursement for covered services. I authorize LiveFree Medical to contact me by phone or mail regarding my medical supplies. This authorization will remain in effect until a written notification by myself or my legal representative has been received. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments, coinsurances and/or deductibles for which I am responsible.

I have also received or have been instructed on where to find a copy of the following:

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| ☒ LiveFree Patient Welcome Packet | ☒ Patient Rights and Responsibilities | ☒ Wound Care Instructions |
| ☒ Medicare Supplier Standards | ☒ Notice of Privacy Practices | ☒ Return Policy |
| ☒ Suggestion & Complaint Procedures | ☒ Warranty Information | ☒ Garment Donning Instructions |

By signing this form, I am confirming that I have read, received, and been instructed in detail on the items above.

Patient Name

DOB

Patient ID

Patient Signature

Date

If patient is unable to sign, authorized persons signature:

Name _____ Relationship _____

Signature _____ Address _____

Date _____ Phone _____