
(Patient's Name)

Assignment of Benefits/Authorization to Release Information

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Hanger Prosthetics & Orthotics, Inc. for any covered services furnished by Hanger Prosthetics & Orthotics, Inc. I agree to pay to Hanger Prosthetics & Orthotics, Inc., the deductible and/or coinsurance on my claim.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete.

If this is a private claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

I acknowledge receiving a copy of Hanger Prosthetics & Orthotics, Inc.'s Notice of Privacy Practices (NPP), dated April 14, 2003 and Hanger's Main Patient Brochure which includes:

Welcome Letter
Bill of Rights

Medicare Supplier Standards
Warranty

Mission Statement
Patient Responsibilities

Patient or Representative Signature: _____ Date: _____

If Representative, please complete below.

Printed Name: _____

Address: _____

Relationship to Patient: _____

Reason for Patient's Inability to Sign: _____

For Notice of Privacy Practices only, describe the Personal Representative's authority to act on behalf of the patient.
