Authorization of Billing

This form is required to bill on your behalf

My signature and date in the box below authorizes each of the following:

1. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s) on my behalf.
2. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

The Diabetic Shoppe and/or any of their corporate affiliates to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medications(s) provided.

SIGN, DATE AND RETURN ENTIRE FORM IMMEDIATELY!

In order for us to bill Medicare and/or other insurance for your medical supplies and/or medications, this form must be completed, signed, dated and returned immediately.

I authorize The Diabetic Shoppe and/or any of their corporate affiliates to directly bill Medicare, Medicaid, Medicare Supplemental, or other insurer(s) on my behalf, for medical supplies and/or medications furnished to me by The Diabetic Shoppe and assign my rights to benefits from such insurers to The Diabetic Shoppe, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services.

Your Phone #: (_____)_____ **Email:_____**

Alternate Contact Name:_____

Alternate Phone #: (_____)_____

Please print your name:_____

SIGN YOUR NAME HERE _____ **TODAY'S DATE** _____

Month/Day/Year

The DIABETIC Shoppe
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Charleston, MS 38921-2413

Ph: 1-888-571-3533
Fax: 1-888-377-2224

Accredited by
JCAHO