Gaboro Medical Supply
140 North 2nd Street
Unit 2
Stroudsburg, PA 18360
570-984-4700
gaboromed.com

Assignment of Benefits and Release Form

Note: Please read all the following documentation within this packet.

My signature and date on the lines below authorize each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplement or other insurance benefits to Gaboro Medical Supply for medical supplies and/or medication(s) furnished to me (Check one)
   - ☐ Wound Care/Urological Supplies
   - ☐ Inco/Ostomy Supplies
   - ☐ Diabetic Equipment/Supplies
   - ☐ Nebulizer Equipment/Supplies
   - ☐ Off-the-Shelf Orthotics
   - ☐ DME/Service
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurance(s)
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurance(s) and their agents and assignments
4. Gaboro Medical Supply to obtain medical or other information necessary in order process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided
5. Gaboro Medical Supply to contact me by telephone, SMS text, mail, or email regarding my medical supplies and/or medication(s) order
6. I hereby certify that I have received a copy of the Gaboro Medical Supply Notice of Privacy Practices, Equipment Warranty Information, and Supplier Standards
7. I have received instruction on how to use the device or product supplied to me by Gaboro Medical Supply

Signature Required

Patient/Representative Signature:_____ Date:_____

Patient's Full Name & Date of Birth:_____

Relationship to Patient (if applicable):_____

Reason for Patient not signing (if applicable):_____

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance(s) be made on my behalf to Gaboro Medical Supply for any medical supplies and/or medications furnished to me by Gaboro Medical Supply, I authorize any holder of medical information about me to release to Gaboro Medical Supply my physician(s), caregiver(s), CMS, its agents and to my primary and/or other medical insurance(s) any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurance(s) and for which I am responsible.