kph HEALTHCARE SERVICES, INC.

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

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

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to *KPH Health Services, Inc.* and/or any of our corporate affiliates *Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc.,* for medical supplies and/or medication(s) furnished to me by *KPH, Inc.*

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. *KPH Health Services, Inc.* and/or any of our corporate affiliates *Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc.* 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 medication(s) provided.

5. *KPH Health Services, Inc.* and/or any of our corporate affiliates *Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc.* to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Phone __ __ __ - __ __ __ - __ __ __ __

Sign Name Here _____ **Date** _____

Print Name Here _____

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to KPH Health Services, Inc. and/or any of our corporate affiliates Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc. for any medical supplies and/or medications furnished to me by KPH Inc. I authorize any holder of medical information about me to release to KPH, Inc., 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. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

Your Medicare # _ _ _ _ _ _ _ _ _ _ _

Insurer /other than *or* in addition to Medicare) **Policy#**_____

Insurer Phone#(____)_____

Please correct *any* errors in your name *and* address below.

UPDATED July 2019

Kinney DRUGS Experience the Difference | PROACT INC | HEALTH DIRECT INSTITUTIONAL PHARMACY SERVICES | NOBLE HEALTH SERVICES