FUNDING

# ASSIGNMENT OF BENEFITS (AOB) and PATIENT RELEASE FORM

**CLIENT:** *The client is the person who will be receiving the equipment or services.*

Client Name: _____ Client Date of Birth: _____

**Insurance Policy Holder** ***(this must be completed in its entirety when a private insurance policy is present)***

Relationship to Client: Spouse Parent Legal Guardian Other (please specify): _____

Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone: _____ Alt Phone: _____ Work Phone: _____

Current Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Are you now in the military/Were you discharged within the last ninety days? Yes No

- I request that payment of authorized health care benefits be made on my behalf to PRC-Saltillo, 1022 Heyl Road, Wooster, Ohio 44691, for any equipment or services provided to me by PRC-Saltillo. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services.
- I understand PRC-Saltillo's return policy gives me (30) days from the date of shipment to call to notify PRC-Saltillo of any item(s) being returned. At that time, a return authorization number will be issued and I will have (15) days from the date of the notification to return the item(s) for a full refund. The refund will be issued to the paying source. PRC-Saltillo will use their discretion to accept any returns beyond the initial notification of (30) days. A restocking fee will apply.
- I acknowledge that I have received and understand PRC-Saltillo's privacy policy and Patient Bill of Rights.
- I acknowledge that I have been instructed to direct questions, complaints or concerns regarding the performance of my equipment, supplies and/or service to PRC-Saltillo at (800) 262-1990 (8:00 AM – 7:00 PM EST). I have been advised that PRC-Saltillo is responsible for resolving my questions or concerns and it is PRC-Saltillo's goal to respond to questions and concerns within (14) business days of my contact to PRC-Saltillo.
- I understand that I am financially responsible for any charges not covered by my health care benefits. (PRC-Saltillo will contact guardian/advocate prior to shipping order.)
- I understand that it is my responsibility to notify PRC-Saltillo of any new insurance orchanges in my health care coverage. If a change in my health care coverage is not reported prior to the services being provided, I understand that I am financially responsible for any charges if payment is denied.
- I acknowledge that I have received and understand the Durable Medical Equipment, Prosthetics/Orthotics & Supplies (DMEPOS) Supplier Standards. (Medicare recipients only.)
- I confirm that I am not receiving in-home or facility based hospice care, skilled nursing or hospital based care. I understand that if the Medicare part B claim denies due to enrollment in the above listed types of care, I assume full financial responsibility for the equipment provided by PRC-Saltillo. (Medicare recipients only.)

Not all services and/or equipment may be covered or paid for by the Responsible Party's (primary policy holder's) private insurance. The Responsible Party agrees to pay all deductibles, co-pay, non-covered services/equipment, and any portion of covered services not paid in full by private insurance, when applicable. The Responsible Party understands that payments are due immediately upon presentation of the bill. The Responsible Party(ies) agree that PRC-Saltillo may use any information provided herein for collection purposes.

By signing below, I agree that this Contract shall be governed by the laws of the State of Ohio, without regard to the principles of conflicts of laws. The venue for any disputes will be exclusively with the appropriate court in Wayne County, Ohio.

**Signature or Mark of Responsible Party:** _____
*(If Medicaid, client signs. If private insurance, policyholder signs.)*

**Responsible Party's Printed Name:** _____

**Witness Signature and Relation to Policy Holder:** _____
*(Required if patient is the policyholder and unable to sign.*