



1-800-977-0351
Fax: 1-800-977-0601
P.O. Box 267970
Weston, FL 33326-9895

Authorization to Bill

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.
3. NationsHealth and/or any of their corporate affiliates to obtain medical or other information necessary in order to process claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(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.

SIGN YOUR NAME HERE

TODAY'S DATE

I authorize NationsHealth 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 NationsHealth and assign my rights to benefits from such insurers to NationsHealth. I authorize any holder of medical information about me to release to NationsHealth, 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 # (____) _____ - _____

Your Medicare # - - -

Your Insurer _____ Policy # _____
(Other than or in addition to Medicare)

Insurer Phone # (____) _____ - _____