PLEASE FILL OUT THE HIGHLIGHTED PART, SIGN, & RETURN THIS BLANKET ASSIGNMENT

BLANKET ASSIGNMENT

NAME:_____**D.O.B**._____/_____/_____

ADDRESS:_____

CITY:_____**ST**:_____**ZIP**:_____

PHONE (_____)_____-_____ **DATE OF SURGERY**:_____

MEDICARE NUMBER:_____ M**EDICAID NUMBER**:_____

INSURANCE NAME:_____**ADDRESS**:_____

CITY:_____**ST**:_____**ZIP**:_____

POLICY#:_____**GROUP**:_____

POLICY HOLDERSNAME:_____

A TEXAS CORPORATION LOCATED AT:

U S OSTOMY SUPPLY, INC.
2350 AIRPORT FREEWAY, SUITE #230
BEDFORD, TX 76022
TOLL FREE #: 1-800-866-3002

FOR MEDICAL SUPPLIES FURNISHED TO ME BY THAT SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION TO RELEASE TO INSURANCE CARRIER, OR HEALTH FINANCE ADMINISTRATION, AND THE SUPPLIER AND ITS AGENTS, OR ANY CO-INSURANCE CO., NAY MEDICAL AND FINANCIAL INFORMATION NEEDED TO DETERMINE THESE BENEFITS.

_____
SIGNATURE OF BENEFICIARY

IF THE BENEFICIARY IS NOT ABLE TO SIGN, NAME OF PERSON AUTHORIZED TO SIGN FOR HIM/HER.

_____ _____
SIGNATURE OF AUTHORIZED PERSON **RELATIONSHIP**

By signing , it is an acknowledgement that I have received a copy of **CMS MEDICARE DMEPOS SUPPLIER STANDARD FORM**

_____
SIGNATURE