BACK & BODY PAIN RELIEF, P.C.

SHAN SIVENDRA, M.D.
DAVID PERNA, D.C., C.C.E.P.
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PHONE: 908-325-3000
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Assignment of Benefits (AOB)
This AOB form is required to bill on your behalf!

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

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Back and Body Pain Relief for medical supplies and/or medication(s) furnished to me by Dr. Shan Sivendra

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. Back and Body Pain Relief 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. Back and Body Pain Relief 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.

Your Phone # (____)_____

SIGN YOUR NAME HERE _____ TODAY'S DATE / /

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Back and Body Pain Relief for any medical supplies and/or medications furnished to me by Back and Body Pain Relief. I authorize any holder of medical information about me to release to Back and Body Pain Relief 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.

MEDICARE # HERE

Insurer_____ **Policy #**_____
(other then or in addition to Medicare)

Insurer phone #_____