



"Your National Diabetic Supplier"®

19 S. Dixie Highway
Lake Worth, FL 33460
PH: (800) 920-0411
FAX: (800) 977-7689

Date:

NAME
ADDRESS
ADDRESS

Assignment of Benefits Form

I, _____, request that authorized medical benefit payments be made on my behalf to Dia-Care, Inc., for any diabetic, ostomy and/or home medical supplies or equipment furnished to me by this provider.

I, _____, authorized the release of medical record information to Dia-Care, Inc. to determine benefit for services payable.

I am authorizing _____, _____
(Name of Personal Representative) (relationship to me)

to discuss my health and billing issues.

Please enclose a copy (front and back) of your Medicare card and other applicable insurance cards.

Signed, _____
PT NAME

Please return this form within 5 days

Thank you very much for taking the time to fill out this form and returning it to Dia-Care.

Diacarerx.com