EHCS
Edwards Health Care Services

LIGHTING THE WAY TO BETTER HEALTH!

Assignment of Benefits and Financial Responsibility

Customer Name: _____ **Account Number**: _____

Welcome to Edwards Health Care Services, Inc. (EHCS). So that we may accurately and promptly bill Medicare and /or your other insurance, we need you to read, sign, and return this form to EHCS upon receipt. For faster service, you may complete this form online at https://www.myehcs.com/aob/.

It is a requirement from your insurance that we have your handwritten or electronic signature on file, authorizing EHCS to bill your insurance on your behalf. If you do not complete this form, we cannot bill your insurance, and you will be responsible for payment for your recent order.

If I receive an insulin pump as a rental per my insurance policy, I understand it will be a 10- to 13-month agreement and the pump will have a 4-year warranty from the manufacturer. During the rental period, the pump remains EHCS property until the rental period ends, and I will contact EHCS immediately if I stop using the pump or if my insurance changes during this time.

Verification of benefits is not a guarantee of payment. There is no way to determine if a claim will be applied to your deductible or co-pay until after the claim is processed.

I hereby authorize Medicare and/or my other third-party insurance providers to pay my medical equipment, supplies and pharmacy benefit directly to EHCS for products furnished to me by EHCS. I further authorize any holder of personal health information (PHI) about me to release such information if required for EHCS to file and process claims on my behalf. I authorize EHCS to release to the Center for Medicare & Medicaid Services (CMS), third party payer and/or its agents any information needed to determine Medicare benefits or for audit purposes.

I have received a copy of EHCS Statement of Privacy Practices as applicable to the Health Insurance Portability and Accountability Act (HIPAA), as well as a copy of CMS' Supplier Standards and a copy of the Client/Patient Bill of Rights and Responsibilities. I understand how to use the products that have been dispensed to me or will receive training upon receipt, and warranty information is included with those products that carry a warranty.

I have received information on how to voice any concerns.

I understand that I am responsible to pay EHCS for any supplies or services not paid in full by my insurance. If my insurance should pay benefits or process claims directly to me for any merchandise provided by EHCS, I will either endorse all checks as “Pay to the order of Edwards Health Care Services, Inc.” or pay EHCS by personal check or credit card. I will notify EHCS of any changes in my insurance benefits, coverage, carrier, or physician.

I authorize EHCS to contact me by telephone, auto call, mail, email, text, or other means to obtain authorization for shipments; or inform me of product recalls, releases, and/or introductions; and/or to answer any billing, product, or prescription questions.

I hereby authorize EHCS to release to their company affiliates my personal health information (PHI) to receive information about additional products and services related to my diagnosis and/or products furnished to me by EHCS.

Print Name: _____ **Date**: _____

Signature: _____ **Phone Number**: _____

Email Address: _____ **Cell Number**: _____

Emergency Contact: _____ **Contact Phone Number**: _____
(not living with you)