CERTIFIED

Certified Prosthetics & Orthotics, LLC
Fort Collins • Greeley • Denver
Toll Free 1-800-466-7015
www.certifiedop.com

ASSIGNMENT OF BENEFITS/ MEDICAL RELEASE FORM

ASSIGNMENT OF BENEFITS

The customer requests that payment of authorized insurance benefits be made on the customer's behalf to **CERTIFIED** for any services furnished.

The customer understands that the signature requests the payment by the insurance carrier be made directly to **CERTIFIED.**

MEDICAL INFORMATION RELEASE AUTHORIZATION

I authorize any holder of medical or other information about me to release to **CERTIFIED** any information for this or any related health claim. I agree to permit a copy of this authorization to be used in place of the original. I authorize **CERTIFIED** to release records for the purpose of obtaining payment from Medicare, Medicaid, or _____.

I request payment of authorized benefits be made on my behalf to **CERTIFIED**. If signed by someone other than the patient, I attest I have the authority to sign on the behalf of the patient.

PLEASE PRINT

Customer's Name:_____ Date:_____

Parent, Guardian or Authorized Name:_____

Relationship to Customer:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____

_____

Customer's Signature

_____

Parent, Guardian or Authorized Signature