Assignment of Insurance and Benefit Rights and Release of Information

Print Patient Name: _____

Address: _____

Date of Birth: _____ Telephone Number: _____

Thank you for your interest in receiving your medications and medical supplies/devices from Marietta Memorial Specialty Pharmacy.

NONDISCRIMINATION STATEMENT
Memorial Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or gender identity and transgender.

LANGUAGE AND HEARING IMPAIRED
ATTENTION: If you speak Spanish or Chinese or have a disability that impairs your ability to communicate effectively, language assistance services, free of charge, are available to you. Please call 740-374-1436. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 740-374-1436. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務 。 請致電 740-374-1436 。

We are glad you chose our pharmacy to get your specialty medications, medical equipment, and supplies/devices. Our billing department will submit all claims for you to ensure appropriate coverage of the products and services we provide. Please sign this Assignment so that we may submit your claims to Medicare, Medicaid, and/or third-party health insurance provider. Furthermore, in the event the undersigned is entitled to medical benefits, of any type whatsoever, arising out of any policy of insurance which insures patient or any other party liable to patient, the rights and benefits of such policy are hereby assigned to Memorial Health System ("MHS") as the undersigned's duly authorized representative for: i) application on patient's bill and receipt of full payment under the policy; ii) initiation, pursuit, and prosecution of administrative appeal remedies and all other legal and equitable remedies with any said insurers or providers of medical benefits; iii) obtaining a copy of the insuring agreement, governing plan, summary document, and settlement of information; and iv) obtaining a copy of any necessary medical information from providers. Additionally, this Assignment is effective for application where the patient may be eligible for reimbursement for certain medications or devices through the medication or device manufacturer. The undersigned authorizes the use of the signature below on all insurances and/or employee health benefits claims and appeal submissions, and for medication/device manufacturer reimbursement applications. The patient and/or undersigned understand and agree that Memorial Health System may or may not pursue any policy of insurance or medication/device manufacturer reimbursement, within its sole discretion resulting in patient and/or undersigned's responsibility for all or some of the charges. A copy of this Assignment is to be considered as valid as the original.

1. I understand that signing this form authorizes Marietta Memorial Specialty Pharmacy to submit claims on my behalf directly to Medicare, Medicaid and/or third-party health insurance provider. Marietta Memorial Specialty Pharmacy will accept assignment of these benefits. This means that Marietta Memorial Specialty Pharmacy will receive direct payment for the medications, supplies, and services provided. I agree to cooperate fully to secure such payment. I acknowledge that I am responsible for payment of copay, deductibles, and items not offered as a benefit. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. Furthermore, should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. Additionally, the patient and/or undersigned agree, in order for Memorial Health System to collect amounts owed, we may contact you using pre-recorded/artificial voice and electronic messages by: i) telephone, including wireless telephone numbers, ii) text messages, and iii) e-mail, which could result in charges to you.

2. I hereby authorize Marietta Memorial Specialty Pharmacy to obtain my prescription history electronically.

3. I hereby authorize Marietta Memorial Specialty Pharmacy to obtain and use my electronic photo for registration and identification purposes.

4. I understand that signing this form authorizes the release of medical or other information to Medicare, Medicaid, and third-party health insurance provider by Marietta Memorial Specialty Pharmacy.

5. I understand that I must return this signed Assignment to Marietta Memorial Specialty Pharmacy so that Marietta Memorial Specialty Pharmacy can continue to provide me with specialty medications, supplies, and services. I understand that if I choose not to sign and return this form, Marietta Memorial Specialty Pharmacy will not be able to bill Medicare, Medicaid and/or potentially third-party health insurance providers for the specialty medications, services and supplies.

6. I acknowledge receipt of the Notice of Privacy Practices & Patients' Rights & Responsibilities, CMS supplier standards, Product instructions, Complaint process, Warranty Information (see attached sheets).

7. I understand that I can request to cancel or revoke the Assignment. In order to cancel or revoke this Assignment, a signed letter by myself or my legal representative must be submitted in writing.

8. This Assignment shall be governed by and interpreted in accordance with the internal laws of the State of Ohio. Washington County, Ohio shall be the sole and exclusive venue for any litigation as between the parties that may be brought under or arise out of this Assignment.

_____ _____

Signature Date

If someone other than the patient/beneficiary is signing this Assignment, please complete the following information for the person signing this Assignment:

Print Name: _____
Relationship to beneficiary: _____ Phone: (_____) _____ - _____
Street address of person signing: _____
City: _____ State: _____ Zip: _____

Reason why beneficiary cannot sign this form: _____ By signing on behalf of the patient, I acknowledge that I have the legal authority to do so.