HIGH STREET DISCOUNT PHARMACY

ASSIGNMENT OF BENEFITS

Patient Name *(Printed)* _____

Address _____

Phone Number _____ DOB _____

I assign the right and responsibility to **HIGH STREET DISCOUNT PHARMACY** to bill on my behalf, and accept payment for Medicare DMEPOS products and services provided to me, the Beneficiary.

I understand that I am responsible to pay any deductible amount applied to the claims and the coinsurance, which is 20 percent of the allowable or approved charge for a product or service.

I permit **HIGH STREET DISCOUNT PHARMACY** to release and collect my health information, and other information, as required (and as permitted by the HIPAA Regulations) from my health care providers and Medicare to receive payment from Medicare.

I understand that this form will be maintained and made available to Medicare or its representatives.

_____ _____

Beneficiary/Caregiver Signature Date

_____

Caregiver Printed Name (If Applicable)