Chenet Cosmetic and Family Dentistry
135 Cumberland Road, Suite 104
Pittsburgh, PA 15237
412-367-0367

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to [Insert Provider Name or Names Here] and/or any of our corporate affiliates [Edit or remove if not applicable] for medical supplies and/or medication(s) furnished to me by [Provider Name].

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. [Provider Name] and/or any of our corporate affiliates [see above] to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. [Provider Name] and/or any of our corporate affiliates [see above] to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # ( )

SIGN YOUR NAME HERE | TODAY'S DATE / /

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to [Provider Name] and/or any of our corporate affiliates [see above] for any medical supplies and/or medications furnished to me by [Provider Name]. I authorize any holder of medical information about me to release to [Provider Name], my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

YOUR MEDICARE # ☐☐☐-☐☐-☐☐☐☐-☐

Insurer _____ Policy # _____
(other than or in addition to Medicare)

Insurer Phone # ( ) _____

Please correct any errors in your name and address below.