

# INSURANCE BILLING AUTHORIZATION

This form is required to bill on your behalf.

**In order for us to bill Medicare and/or other insurance for your medical supplies, this form must be completed, signed, dated and returned immediately!**

- My signature on this form authorizes Life Care Diabetic Supplies, Inc. (Life Care) as of this day, \_\_\_\_\_, to submit insurance claims and authorizes direct reimbursement to Life Care for **medical supplies, services, products and/or medical equipment I have received from them.**
- I authorize Life Care and/or any of their authorized corporate affiliates to exchange information with my physician, insurance company, Medicare, Medicaid, their agents and assigns, information necessary in order to process my claim(s). The above includes determining eligibility and seeking reimbursement for medical supplies and/or medical equipment provided to me.
- I authorize Life Care and/or any of their authorized corporate affiliates to contact me by telephone or by mail regarding my medical supplies and/or medical equipment to ensure accuracy of order.
- I understand that if my insurance company reimburses me directly instead of Life Care, I will submit payment in the same amount to Life Care.
- I agree to pay all amounts that are not covered by my insurance(s) including applicable co-payments and/or deductibles for which I am responsible.
- I understand that I will not be receiving the same product(s) from another Medicare approved company, as Medicare/Insurance will only pay one provider at a time.

YOUR PHONE # ( \_\_\_\_\_ ) \_\_\_\_\_

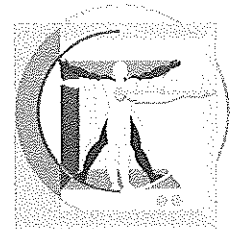
**SIGN YOUR NAME HERE**  **TODAY'S DATE**

**YOUR MEDICARE #**    -   -     -

INSURER \_\_\_\_\_ POLICY# \_\_\_\_\_  
*(other than or in addition to medicare)*

INSURER'S PHONE # ( \_\_\_\_\_ ) \_\_\_\_\_

**PLEASE PRINT YOUR NAME AND ADDRESS BELOW:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



*Life Care  
Diabetic Supplies, Inc.  
(800) 815-1577  
Fax (877) 288-4656*