Assignment of Benefits

This important form is required to bill on your behalf.

Please remember to sign, date and return immediately.

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

1. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s) on my behalf.
2. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.
3. Spruce Rx Pharmacy and /or any of their corporate affiliates 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.

SIGN YOUR NAME HERE ____________________ TODAY'S ____________

By signing this form, you are authorizing Spruce Rx Pharmacy to contact you by telephone.

Month/Day/Year

I authorize Spruce Rx Pharmacy and/or any of their corporate affiliates to directly bill Medicare, Medicaid, Medicare Supplemental, or other insurer(s) on my behalf, for medical supplies and/or medications furnished to me by Spruce Rx Pharmacy and assign my rights to benefits from such insurers to Physician Choice Pharmacy. I authorize any holder of medical information about me to release to Spruce Rx Pharmacy , my physician(s), caregiver, CMS, its agents and to primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services.

Your Phone # _(_____)________________________

Your Medicare # ☐☐☐ - ☐☐ - ☐☐☐☐ - ☐

Email ____

Your Insurer ______________________________ Policy # ___________________________

(Other than or in addition to Medicare)

Insurer Phone # __(______)__________________________

Name: ____

Address: ____

City: ____________________________ State: ________ Zip: ___________

Spruce Rx Pharmacy

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