

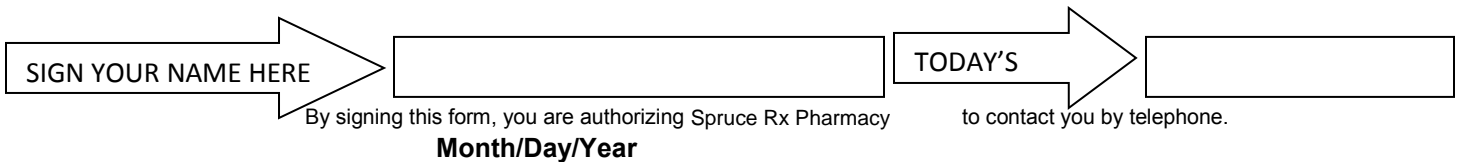
Assignment of Benefits

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.



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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