



Assignment of Benefits & Release of Information

I authorize the release of any medical or other information necessary to determine these benefits payable and to process a claim for related equipment or services to the organization, the Health Care Financing Administration, my Insurance Carrier or other medical entity. In the case of a denial I authorize Tobii to refer my information to an advocate to pursue action.

Initials:

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare Beneficiary, be made on my behalf to Tobii Assistive Technology, Inc. (tobiiATI) for any equipment or services provided to me by the organization. Should I receive payment directly from the insurance company I agree to forward the check and "Explanation of Benefits" to tobiiATI within 10 days of receipt to credit my account. If I fail to provide this information I understand that I will be held legally responsible for payment in full for all equipment or services which have been provided by Tobii ATI.

Initials:

I understand that I am only financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim; if the submitted claims, or any part of them, are denied for payment, a member of the Funding Department will contact me to communicate the denial to discuss options. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurance. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received. THIS DOES NOT APPLY WHEN MEDICARE DETERMINES THE BALANCE TO BE THE CONTRACTOR'S OBLIGATION, OR TO MEDICAID RECIPIENTS.

Initials:

- Beneficiary Name:
- Policy Holder Name:
- Policy Holder SSN:
- Policy Holder Date of Birth:
- Policy Holder Signature or mark:
- Date Signed:
- Witness Signature (if Policy Holder provided a mark):
- Relation to beneficiary:

*****MEDICARE RECIPIENTS ONLY*****

I certify that I AM NOT receiving hospice care, currently in a skilled nursing facility or in the hospital. I also understand that if Medicare denies coverage due to enrollment in the above listed types of care, that the Funding Department will notify me by phone to communicate that I need to assume full responsibility for the cost of all equipment provided by Tobii ATI.

Initials: