



NATIONWIDE MEDICAL, INC.
28632 Roadside Dr., #210
Agoura Hills, CA 91301
Telephone (877) 307-2727 Fax (866) 649-2727
www.NationwideMedical.com



Dear Medicare Patient,

Nationwide Medical, Inc. is providing your follow-up care for your CPAP/Bi-Level machine. We will be calling you every three months to answer any questions or concerns you may have about your CPAP/Bi-Level machine.

Attached you will find the Assignment of Benefits (AOB) for you to sign and return to our office. This is the form Medicare requires us to send that allows us to bill on behalf of your for your CPAP/Bi-Level equipment and/or supplies. **The return of this AOB is required to allow us to provide these supplies to you.**

If you have any questions regarding the equipment set-up, cleaning procedures, or how to get replacement supplies don't hesitate to call our toll free number (877) 307-2727 and ask for Patient Services.

Thank you for allowing us to provide you with excellent healthcare.

Sincerely,

Ross Shaw



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ASSIGNMENT OF MEDICAL BENEFITS

Regulations authorize Medicare to pay for claims submitted by a supplier only if the Beneficiary or the person authorized to request payment on the Beneficiary's behalf assigns the claims to the supplier and the supplier accepts assignment. **Nationwide Medical, Inc.** can only receive Medicare payment if the Beneficiary (patient) assigns his or her Medicare benefits to **Nationwide Medical, Inc.** In accepting the assignment, we accept Medicare's determination of the approved amount as the full fee for the service(s) rendered. Please sign and date the statement below and return it at your earliest convenience. Thank you for your cooperation.

_____ (Beneficiary / Patient)
PRINT NAME

DATE OF BIRTH

I (the patient and/or Caregiver) authorize Nationwide Medical, Inc. to obtain or release to the Healthcare Financing Administration, any third party payor, and their respective agents, any medical information about me, needed to determine benefits payable and/or patient care on my behalf.

I request that payment of authorized Medicare benefits be made on my behalf to **Nationwide Medical, Inc.** (supplier) for any services furnished to me by **Nationwide Medical, Inc.** As the supplier of services for this patient, **Nationwide Medical, Inc.** assumes unconditional responsibility for refunding any overpayment resultant of the carrier not having received prompt notice of the return of, or the end of need for the supplies, or the demise of the enrollee. Per your Physician's order we will send you supplies for your PAP therapy on a quarterly basis. We will call you before sending the supplies and you agree to let us know if you do not want or need the supplies. I authorize **Nationwide Medical, Inc.** to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X _____
Patient Signature

Date

X _____
Signature if other than patient

Date