Memorial Specialty Pharmacy

Medicare Assignment of Benefits and Release of Medical Records

****NOTICE Medicare Part B Patient, Signature Required****

ASSIGNMENT OF BENEFITS: MEDICARE PART B LIFETIME AUTHORIZATION: I hereby assign to Memorial Specialty Pharmacy all insurance benefits and payments to which I am entitled from all third-party payors that are obligated to pay for my medications, including Medicare and/or Medicaid if applicable, for any services, medications, equipment or supplies which are furnished to me by Memorial Specialty Pharmacy, and authorize Memorial Specialty Pharmacy to seek such insurance benefits and payments from all third-party payors that are obligated to pay for my medications directly and that this assignment of benefits shall be ongoing and continuous, unless and until canceled by me in writing. Cancellation of this assignment of benefits shall become effective when the cancellation is delivered to Memorial Specialty Pharmacy, my insurer(s) and each third-party payor that is obligated to pay for my medications. I request that payment of authorized Medicare benefits be made directly to Memorial Specialty Pharmacy on my behalf, for any medications furnished to me by Memorial Specialty Pharmacy.

Beneficiary Name: _____

HI CN # _____

Account # _____

Start Date: _____

Beneficiary Signature: _____ Date: _____

If beneficiary is unable to sign, the following information must be completed in full by the Authorized Representative:

Beneficiary Name: _____

Authorized Representative: _____

Relationship to Beneficiary: _____

Medical Reason for Beneficiary Inability to Sign: _____