Advanced
PHYSICAL THERAPY
OF CENTRAL FLORIDA, INC.

# BENEFICIARY CHECKLIST

Patient Name Tanmoy Raha

Medicare Number: _____

**STAFF PLEASE INITIAL ALL BELOW AND HAVE PATIENT SIGN AT THE BOTTOM:**

Sanjay _____ Called Medicare to verify eligibility

Sanjay _____ HIPAA privacy policy

Sanjay _____ Equipment warranty policy

Sanjay _____ Protocol for resolving complaints

Sanjay _____ Supplier standards

Sanjay _____ Assignment of benefits

Sanjay _____ Delivery ticket

Sanjay _____ Instructed on use

I have received and understand the above information.

Tale _____ 11/03/2017 12:45 PM

Patient's Signature Date

**1202 SW 17th Street, #201-229, Ocala, FL 34471**

Advanced
PHYSICAL THERAPY
OF CENTRAL FLORIDA, INC.

# Assignment of Benefits, Release of Information Authorization and Insurance Coverage Disclosure

Patient/Customer Name Tanmoy Raha
Street Address Garia
City kolkata State Alabama Zip Code 45254
Social Security Number 111-222-3333
Home Telephone Number
Other Telephone Number (999) 999-9999

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**By signing and dating this form, I hereby grant authorization for the following to ADVANCED PHYSICAL THERAPY OF CENTRAL FLORIDA, INC., a medical service, equipment and supply provider and their agents assigns:**

a. To be granted and accept assignment of payments for Medicare, Medicaid,

Medicare Supplemental or other medical insurance benefits for services, equipment and/or supplies furnished to me.

b. To submit claims or invoices to Medicare, Medicaid, or my other medical insurer(s), directly on my behalf, for services, equipment and/or supplies furnished to me.

c. To release my medical information or other pertinent information to Medicare, Medicaid, Medicare Supplemental, or other insurer or their agent or assigns.

d. To request, receive, and maintain in their files, medical or other information necessary to process my orders, submit claims, receive payment and comply with applicable rules, guidelines, regulations, and laws governing the services, equipment and/or supplies furnished to me.

e. To contact me by telephone or mail regarding services, equipment and/or suppliers.

f. To bill me directly for approved amounts not covered by Medicare, Medicaid, Medicare Supplemental or other medical insurance benefits.

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## This authorization/release form covers all services and supplies provided to me by ADVANCED PHYSICAL THERAPY OF CENTRAL FLORIDA, INC. including the following equipment:

BREG Custom Knee Brace Order

I have read, understand, and agree with the information on this authorization/release form.

| | |
|---|---|
| Patient/Customer Signature | 11/3/2017 12:45:54 PM<br>Date Signed |
| If other than Patient/ Customer * | Date Signed |
| Tanmoy Raha<br>Print Name | Telephone Number |
| Garia<br>Street Address | kolkata ,Alabama ,45254<br>City, State, Zip Code |

* Relationship to Patient/Customer:

_____ Authorized Caregiver

_____ Authorized Family Member

Other, please describe: _____

**1202 SW 17th Street, #201-229, Ocala, FL 34471**

Advanced Physical Therapy of Central Florida, Inc.
5036 SE 110th Street
Belleview, FL 34420
Phone:352-693-3378 Fax:888-758-9645