Advanced Diagnostic Solutions, Inc.
Fast! Efficient!! Courteous!!!

Assignment of Benefits (AOB) & Medical Release

Patient Information

Name: _____

DOB: _____ ❑ Male ❑ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Local DME Supplier *(Test Courier)*

Name: _____

Phone: _____

Fax: _____

Contact: _____

Email: _____

Primary Insurance

❑ Medicare ❑ Medicaid ❑ Private Pay ($28.00)

❑ Other Insurance: _____

Member ID/Policy #: _____

Group #: _____ Phone #: _____

Claims Address: _____

City/State/Zip: _____

Medicaid does not cover this test and the patient will be billed at the private pay rate. If the patient has a financial hardship, please include the hardship waiver for this charge to be waived for the patient.

Secondary Insurance

Plan Name: _____

Member ID: _____

Group #: _____ Phone #: _____

Claims Address: _____

City/State/Zip: _____

Some Secondary Insurance Companies do not cover this service which the member will be responsible from the amount left from Primary Insurance. Typical co-pays/coinsurances are in the range of $5 - $15.

Authenticity Statement, Assignment of Benefit & Medical Release

I, the undersigned, certify that I had the pulse oximeter dropped off by the DME Supplier and was provided detailed instructions by ADSI – Medicare Enrolled IDTF. Furthermore, I certify that I was the only person to test with this unit and that I did not alter or attempt to tamper with the unit in any way, shape or form. I authorize the DME Supplier to transmit the oximetry data to ADSI – Medicare Enrolled IDTF to process these test results and release them to my ordering physician and DME Supplier. I authorize ADSI to exclude the first five minutes of test data and the last minute of test data as awake SpO_2 for this nocturnal pulse oximetry.

Pulse Oximeter SN#: _____ Date & Start Time: _____ Date & End Time: _____

I, the undersigned, authorize and release ADSI – Medicare Enrolled IDTF to bill my primary and secondary insurance carrier(s) on my behalf for the cost of the overnight pulse oximetry. Furthermore, I authorize the payment to be made directly to ADSI for the cost of this oximetry test. I also understand that I am financially responsible for the amount that my insurance, primary or secondary, does not cover due to denial(s), co-pays, deductibles or coinsurances and will pay any bill received from ADSI promptly. In the event my insurance coverage has been terminated or I do not have insurance, I agree to pay ADSI the billed amount for this oximetry testing. **Most State Medicaid plans do not cover this procedure and the patient will be charged at the private pay rate.**

I, the undersigned, authorize ADSI (Medicare Enrolled IDTF) to release my medical record chart pertaining to this overnight oximetry test to the above named DME Supplier. Furthermore, I authorize the DME Supplier to speak with my physician about any treatment, present or future, necessary based on the overnight oximetry results provided by ADSI. By signing below I am confirming that I have read and understood this **Medical Release** and agree fully with the terms stated within.

X _____ Date: _____ / _____ / _____

Patient / Caregiver / Power of Attorney Signature

_____ Relationship to Patient: ❑ Caregiver ❑ POA ❑Relative

Print Name ***(If other than patient & mark relationship to patient)***

Fax completed, signed form to ADSI at (352) 274-9122. Any questions please call (352) 293-2810. Thank you.