Active Medical LLC
120 Prosperous Place, Ste 103 Lexington, Ky 40509

I ____________________________ appoint ______________________________ to act as
(name of beneficiary) (name of representative)
my personal representative with Medicare, Medicaid or private insurance.

Their relationship to me is spouse, child, parent, sibling, other ______________________.
(choose one) (or write in)

The reason I cannot sign is: ____.
(list reason)
My representative **does or does not** live with me.
(choose one)
If not, their address and phone number is:

Address: _____________________________________ Phone: __________________

City/St/Zip: ____

Signature: _______________________________ Date: __________________

My signature and date above authorizes the above named person to sign on my behalf for each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to [Active Medical LLC] and/or any of our corporate for medical supplies and/or medication(s) furnished to me by [Active Medical LLC].

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. [Active Medical LLC] and/or any of our corporate affiliates to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. [Active Medical LLC] and/or any of our corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I also agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Active Medical LLC and/or any of our corporate affiliates for any medical supplies and/or medications furnished to me by [Active Medical LLC]. I authorize any holder of medical information about me to release to [Active Medical LLC], my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.