Byram HEALTHCARE®
Part of the Owens & Minor Family

Patient Authorization of Information and Assignment of Benefits

My signature on the line below authorizes the following:

1. I certify that the information given by me in applying for payment under Medicare (Title XVIII of the Social Security Act) and/or any other Medicare Insurance is correct.
2. I authorize the release to Byram Healthcare any medical information including the diagnosis that may be necessary for insurance payment. I authorize the benefits payable to Byram Healthcare on assigned claims. I authorize Byram Healthcare to submit claims to Medicare and/or any other Medical Insurance carrier.
3. I agree to assume responsibility for any balances for supplies furnished to me by Byram Healthcare not approved by my insurance policy. This includes but is not limited to deductibles, coinsurance and non-covered items. I authorize that photo copies shall be valid as originals.

Patient Name (please print):_____

Patient Signature:_____ Date:_____

Patient Account Number:_____

Contact Phone Number:_____

If not the patient, please provide the following information:

Relationship to patient: _____

Reason patient is unable to sign: _____

Address: _____

City/State/Zip:_____ Phone: _____

This important form is required to bill on your behalf. The completed form can be returned by:

Mail: Byram Healthcare
3010 Woodcreek Dr, Suite A
Downers Grove, IL 60515

Fax: 1-866-232-9726

Email: reimburse@byramhealthcare.com

*Please note: if returning this form by fax or email, the form must include an original signature and date. Electronic signatures will be deemed invalid by Medicare.