MEDICO Express
We Speak Your Language
4770 Biscayne Blvd., Suite 780-B, Miami, Florida 33137
www.medicoexpress.org

Authorization of Billing

Sign and Fax Back: 1-305-576-7222

Physician Help Line: 1-877-319-9302

This Important form is required to bill on your behalf. Please remember to sign, date and return immediately.

My Signature and date in the box below authorizes each of the following:

1. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s) on my behalf.

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

3. Medico Express and / or any of their 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.

By signing here, you are authorizing Medico Express to contact you by telephone.

Month / Day / Year

I authorize Medico Express, and/or any of their corporate affiliates to directly bill Medicare, Medicaid, Medicare Supplemental, or other insurer(s) on my behalf, for medical supplies and / or medications furnished to me by Medico Express and assign my right to benefits from such insurers to Medico Express. I authorize any holder of medical information about me to release Medico Express, 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.

Your Phone# _(_____)_____

Your Medicare # ☐☐☐–☐☐–☐☐☐☐–☐

E-Mail_____

Your Insurer_____ Policy#_____

(Other than or in addition to Medicare)

Insurer Phone# _(_____)_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____ Prospect ID: