Advanced Diagnostic Solutions, Inc.

Assignment of Benefits (AOB) & Medical Release

Patient Information

Name: _____

DOB: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Local DME Supplier *(Test Courier)*

Name: Shields Home Medical Equip.

Phone: 870-886-2002

Fax: 870-886-1863

Contact: Janet Owen

Email: jowen.shieldsmedical@outlook.com

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.