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**Authorization to Assign Benefits to Provider**

I hereby request payment of my authorized Medicare or other carrier benefits to be made on my behalf to Piñon Sleep Center for products and services that they have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to release to the Health Care Financing Administration, any other insurer and/or their agents any information needed to determine these benefits. Piñon Sleep Center bills third party payers as a courtesy when appropriate. I understand that I am fully responsible for all deductibles, coinsurance and disallowed items.
Also, I understand that a particular item or services, although it would otherwise be covered, if not “reasonable and necessary” under Medicare standards, Medicare will deny payment.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

If signed by caregiver or other, please list relationship (IE Husband, Wife, RN, etc.)