Mark D. Zeigler DMD
Carmen J. Cagno DMD, INC
724-658-2055

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

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

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Mark D. Zeigler DMD/ Carmen J. Cagno DMD, INC. for medical supplies and/or medication(s) furnished to me by Mark D. Zeigler DMD.

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. Mark D. Zeigler DMD/ Carmen J. Cagno DMD, INC. 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. Mark D. Zeigler DMD/ Carmen J. Cagno DMD, INC. to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I 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.

Your Phone # (____) ____________________

SIGN YOUR NAME HERE ____________________ **TODAY'S DATE** ___ / ___ / ___

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Mark D. Zeigler DMD/ Carmen J. Cagno DMD, INC and/or any of our corporate affiliates [see above] for any medical supplies and/or medications furnished to me by Mark D. Zeigler DMD. I authorize any holder of medical information about me to release to Mark D. Zeigler DMD, 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.

YOUR MEDICARE # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ - ___

Insurer ____________________ **Policy #** ____________________
(other than or in addition to Medicare)

Insurer Phone # (____) ____________________

Please correct any errors in your name and address below.