SunMED Medical Systems, LLC
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AGREEMENT TO ALLOW SUNMED TO BILL YOUR INSURANCE-RETURN REQUIRED

Release of Protected Health Information

I understand that my insurer requires documentation, including prescriptions, about my medical condition to determine if they will cover the medical products provided by SunMED Medical Systems, LLC (SunMED). This information may be maintained by my Physician, Home Healthcare Agency, Healthcare Facility, employer, or other entities. I authorize any holder of medical documentation about relevant conditions for which I am being treated to release that information to SunMED and my Insurance Company to prove that the products are medically necessary.

Assignment of Benefits

I, the undersigned, irrevocably authorize assignments of and direct payments of insurance benefits to SunMED for the medical equipment supplied by SunMED.

In the event that my insurance carrier reimburses me directly instead of SunMED, I will remit a copy of the explanation of benefits and sign the check over to SunMED within two (2) weeks or provide payment in full by credit card or personal check. I understand that if payment is not forwarded, 14 days from the issue date of the check interest of 19% annually will begin to accrue. If payment is not received in 30 days my account will be sent to SunMED collections attorney and payment, interest, and attorney fees will be my responsibility.

I am aware that SunMED will bill my insurance carrier as a courtesy and as a result, I am responsible for my insurance deductible, co-payment/co-insurance, and/or patient responsibility. These out-of-pocket expenses were explained to me prior to receipt of my order. I irrevocably acknowledge that my signature on this document represents that I will be responsible for full payment as determined by my insurance carrier.

I will notify SunMED prior to any changes in my insurance coverage that would impact payment of my claim. If my insurance carrier changes and I do not notify SunMED prior to dispensing my medical products I will be responsible for payment in the even my claim is denied.

I acknowledge I have not received any same or similar items from another provider within the past 60 days. If this is a false acknowledgement, or if the claim denies for a denial reason that allows SunMED to do so, I acknowledge that I will receive an invoice for these denied products and will be responsible for full payment.

CareCentrix patients only: If my Insurance Coverage is managed by CareCentrix, I acknowledge that CareCentrix and not SunMED will bill me for any co-pays, deductibles, or other patient costs associated with my medical products. CareCentrix will only give this information to the member. Contact CareCentrix at 877-725-6525 for information about your account.

Patient Name (please print legibly) _____
Your Signature: _____Date: _____
Relationship if you are not the recipient of the products _____
Reason recipient cannot sign (not home, physically unable, asleep, etc.)

A copy of this signed form will be as valid as an original. Rev. 10/28/2024