ASSIGNMENT OF BENEFITS TO PROVIDER

SERVICE RECIPIENT (PATIENT) | BIRTH DATE

INSURANCE PROVIDER

PLAN MEMBER INFORMATION

(DETAILS FROM INSURANCE CARD OR PLAN)

PLAN/CERTIFICATE/FIRM/GROUP NUMBERS

PLAN MEMBER NAME | PLAN MEMBER BIRTH DATE

PROVIDER INFORMATION

(FILLED OUT BY MEDIGAS)

Medigas Manitoba Limited: 150 McPhillips Street, Winnipeg, MB R3E 2J9

PROVIDER SIGNATURE (OR STAMP) | DATE

PATIENT AUTHORIZATION

I, _____ hereby assign my benefits payable from this claim directly to Medigas Manitoba Limited for medical equipment and supplies provided. I understand that I am financially responsible to the provider for the entire cost associated with this claim.

I authorize Medigas, its employees and authorized agents to share my personal information with my insurance provider.

PATIENT SIGNATURE | DATE