



PLEASE SIGN & RETURN FORM:

FAX: 866-399-9338
EMAIL: webcontact@argencis.com
U.S. MAIL: ARGENCIS
P.O. Box 271195
Oklahoma City, OK 73137

AUTHORIZATION & AGREEMENT FOR SERVICES

THIS FORM AUTHORIZES ARGENCIS TO BILL YOUR INSURER. IT MUST BE COMPLETED & RETURNED ONCE. IF YOU OR YOUR REPRESENTATIVE HAVE COMPLETED & RETURNED THE FORM PREVIOUSLY, PLEASE DISREGARD. IF NOT, PLEASE COMPLETE & RETURN IT ASAP. YOU MAY BE BILLED IF THE FORM IS NOT COMPLETED & RETURNED.

HOME HEALTH CARE

If my insurance is a Medicare plan, I understand that these supplies are not covered if I am receiving any kind of Home Health Services. These supplies must be provided by my Home Health Service Provider. If I choose to accept them while under a Home Health Episode, as defined by CMS, I may be financially responsible for the cost of these items.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid, and Private Insurance benefits be made payable to ARGENCIS for any services or products issued by ARGENCIS. This assignment of benefits may be revoked at any time.

AUTHORIZATION FOR SERVICES

I authorize ARGENCIS to provide supplies and/or services as ordered by my physician. I understand that I have the right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment or medical supplies. I authorize ARGENCIS to bill my Insurance for the supplies provided and understand that I may be responsible for any deductibles or coinsurance. Estimated patient responsibility can be obtained by contacting our billing dept.

RIGHTS AND RESPONSIBILITIES

My signature below acknowledges that I have received the statement of rights and responsibilities and it has been explained to me. The patient rights and responsibilities may be found at www.argencis.com. You may also call to request the policy via mail.

SUPPLIER STANDARDS & NOTICE OF PRIVACY PRACTICES

My signature below acknowledges that I have received a copy of the CMS (Medicare) Supplier Standards and a Notice of Privacy Practices. The Notice of Privacy Practices may be found at www.argencis.com. You may also call to request the policy via mail.

RELEASE OF INFORMATION

I authorize any holder of medical or other information about the below named client to release such information to ARGENCIS, the Centers for Medicare and Medicaid Services and it's agents or any other payable insurance to whom application for payment has been made for services rendered to the below named client; to any physicians, hospitals, other healthcare providers or facilities, institutions, or agencies providing treatment to the below named client.

PRODUCT WARRANTY

Please inspect your package upon delivery and notify ARGENCIS if any supplies are missing or damaged. ARGENCIS will gladly pick up supplies that have been received in error or are damaged in transit. Please contact our office within 48 hours of receiving your order to make arrangements for pick up. All other returns must be sent back to ARGENCIS within 14 days, and should be in new, unopened, and unaltered condition. All returns will undergo a quality control inspection, and credit will be issued on eligible items.

COMPLAINTS/GRIEVANCES

The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process. Please contact ARGENCIS at 800.745.2215 or at www.argencis.com to file your complaint. If we are unable to resolve your concern please contact our Accreditation company, ACHC, at 855.937.2242. If both ARGENCIS and ACHC are unable to resolve your concern, please contact Medicare at 800.MEDICARE.

PLEASE PRINT PATIENT/BENEFICIARY NAME

DATE OF BIRTH

PATIENT OR CAREGIVER SIGN

DATE

Please feel free to contact us with any questions or concerns at 1-800-745-2215 from 9A-5P, Central Time.