



PO Box 585
Sheridan, MT 59749
Phone/Fax: 1-800-853-0310
www.augcomsol.com

Augmentative Communication Solutions

Authorization for Payment

Name: _____
Primary Payor: _____ ID Number: _____
Secondary Payor: _____ ID Number: _____

I request that payment of benefits be made on my behalf directly to AugCom Solutions, PO Box 585, Sheridan, MT 59749 for any and all services provided me by this supplier.

I authorize any holder of medical information about me to release information necessary for Medicare, Medicaid, my private health insurance plan, or any other applicable third party payor and it's agents any information needed to determine these benefits.

Signed: _____ Date: _____
Printed name: _____

Witness (if applicable): _____
Signature

Printed name

Address

If patient is unable to sign, a legal guardian, representative payee, relative, or friend may sign on their behalf.

Signature

Printed name

Address

Relationship

Reason patient is unable to sign

