MOPA, LLC
FAMILY O&P

Manfredi
Orthotic
Prosthetic
Affiliates, LLC

HCFA has selected four (4) regional contractors to process Medicare claims for DMEPOS. Each supplier will be required to submit claims for reimbursement to the carrier having jurisdiction over **your permanent address**: (where you live six months and one day of the year).

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Insurance Assignment: Manfredi Surgical & Orthopedic Co., Inc. (MOPA) will make every effort to bill my insurance carrier/Medicare/Medicaid. However, I understand that I am fully responsible for any denied claim or non-covered service. If reimbursement cannot be obtained, I am willing to pay for the services/supplies provided. I assign to MOPA any and all insurance benefits otherwise payable to me for services or supplies rendered. I agree to forward any payments made to me by my insurance company to MOPA and understand that I am responsible for all charges incurred.

I permit a copy of this authorization to be used in place of the original signature on the HCFA form.

Service Authorization: I request that payment of authorized Medicare/insurance benefits be made either to me or on my behalf to Manfredi Surgical & Orthopedics Co., Inc for services furnished me by that supplier.

I authorize any holder of medical information about me to release to the centers for Medicare & Medicaid services and its agents any information needed to determine these benefits payable for related services.

Signature: _____ Date: _____

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