Tobii ATI provides innovative hardware and software solutions for
individuals with disabilities or special education needs.

Assignment of Benefits & Release of Information

I authorize the release of any medical or other information necessary to determine these benefits payable and to process a claim for related equipment or services to the organization, the Health Care Financing Administration, my Insurance Carrier or other medical entity.

Initials:

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made on my behalf to tobii Assistive Technology, Inc. (tobiiATI) for any equipment or services provided to me by the organization. Should I receive payment directly from the insurance company I agree to forward the check and "Explanation of Benefits" to tobiiATI within 10 days of receipt. I understand that the check and explanation are due to tobiiATI in order to credit my account. If I fail to provide this information I understand that I will be held legally responsible for payment in full for all equipment or services which have been provided by tobiiATI.

Initials:

I understand that I am only financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims, or any part of them, are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received. THIS DOES NOT APPLY WHEN MEDICARE DETERMINES THE BALANCE TO BE THE CONTRACTOR'S OBLIGATION, OR TO MEDICAID RECIPIENTS.

Initials:

Beneficiary Name:
Policy Holder Name:
Policy Holder SSN:
Policy Holder Date of Birth:
Policy Holder Signature or mark:
Date Signed:
Witness Signature (if Policy Holder provided a mark):
Relation to beneficiary:

**********************MEDICARE RECIPIENTS ONLY*************************

I certify that I AM NOT receiving in home or facility based hospice care, skilled nursing or hospital based care. I also understand that if the Medicare part B claim denies due to enrollment in the above listed types of care, I assume full responsibility for the cost of all equipment provided by tobiiATI.

Initials:

Tobii ATI | 333 Elm Street | Dedham, MA 02026 | www.tobiiATI.com | 800-793-9227 | fax 781-461-8213