

ASSIGNMENT OF INSURANCE BENEFITS

NOTE: Please fill in, sign, date, and return to The Back Bubble.

Patient's Name:	
Insurance Carrier:	

I, _____ AUTHORIZE _____ TO PAY BENEFITS DIRECTLY TO THE DURABLE MEDICAL EQUIPMENT SUPPLIER OF THE BACK BUBBLE. THE BACK BUBBLE LUMBAR TRACTION DEVICE HAS BEEN PRESCRIBED TO ME FOR HOME PHYSICAL THERAPY.

SUPPLIER:

THE BACK BUBBLE
RONALD L. CHASES, PRESIDENT
P.O. BOX 1285
SOLANA BEACH, CA 92075
TELEPHONE #: 1-858-481-8715
FAX #: 858-481-1362
Federal Tax ID#: 559-66-1519

SIGN & DATE

THANK YOU.

SIGN:		DATE:	
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BACK BUBBLE
PO BOX 1285
SOLANA BEACH, CA. 92075

Customer Support: 1-800-457-7246 | Back Bubble Fax Number: 858-481-1362

