Lifeline Alliance®
HealthShare

# Assignment of Benefits Form

**Member's name**

First name | M.I. | Last name

This Assignment of Benefits (AOB) form is used to assign benefits directly to your provider.* Once your plan of care has been established, you may submit the completed form. Your provider must also complete and submit the attached W-9 form. Only one AOB form and one W-9 form are required per provider per member.

The AOB ends when the current period of eligibility ends.

In order to cancel an AOB, a letter, signed by the member or the member's legal representative, must be submitted requesting that reimbursement be issued to the member.

***An AOB is only available for home care agencies and facilities within the United States.**

**Provider information** (where payment is to be sent)

Facility/agency or provider name

Federal Employer Identification number

Payment address

City | State

Zip | Phone number

## Assignment of Benefits

**I authorize payment** to be paid to the provider shown above for long term care benefits otherwise payable to me. I understand I am financially responsible to the named provider for the charges not paid or payable under the Lifeline Alliance Long Term Care Benefits Program (LTCBP). I understand that Lifeline Alliance may not be able to honor this request. If they cannot, they will pay the benefits directly to me as the member.

Any person who knowingly and with intent to defraud any LTCBP or other person files an application LTCBP containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

**I certify that the information furnished in support of this claim is true and correct.**

**Note:** A handwritten signature is required.

**Signature** (member or legal representative)

_____ **Date Signed** _____ / _____ / _____

(Required) (Required : mm / dd / yy)

Please return your completed AOB and W-9 forms by email to **claims@lifelinealliance.org, by fax to 800-984-5524, or by mail to Lifeline Alliance 456 A Central Ave, Suite 157 Cederhurst, NY. 11516**