PATIENT AGREEMENT / DETAILED WRITTEN ORDER

Call _____ if you have questions, concerns, or suggestions about our equipment or service.

PATIENT INFORMATION

Female ❑ Male ❑

Name _____
First M Last

Mailing Address _____

_____
City State Zip

Hm # _____ Wk # _____

DOB _____ SSN _____

Employer _____

DETAILED WRITTEN ORDER

Name _____

NPI # _____

Phone # _____

ICD 10 _____

Dispense As Written – Do Not Substitute

Physican Signature: _____
Medicare Requires An Original Signature

Date: _____

Left ❑ Right ❑

MEDICARE

Primary ❑ Secondary ❑

Medicare # _____

Name on Card _____

INSURANCE INFORMATION

Insurance Carrier _____

Insured's Name _____

Relationship to Patient _____

ID # _____

Benefits/Eligibility Phone # _____

Adjuster/Contact _____

DOI _____

ORDER INFORMATION – ITEM 1

MANUFACTURER	OTI PART #	QTY.	PRICE EA.

ORDER INFORMATION – ITEM 2

MANUFACTURER	OTI PART #	QTY.	PRICE EA.

ORDER INFORMATION – ITEM 3

MANUFACTURER	OTI PART #	QTY.	PRICE EA.

COMMENTS: _____

I was hereby given advance notice that Medicare does not pay for cold-therapy products, slings, rib-belts, post-op shoes, cast boots, insoles/shoe inserts, heel cups, wedges/pads, arch supports, elbow protectors, elastic support, and surgical stockings obtained from DME Supplier. I understand that because these items are excluded from Medicare coverage, I am responsible for payment to DME Supplier. Cost for additional medical information required by your insurance company will be your responsibility.

❑ *Visa* ❑ *MC* ❑ *AMEX* ❑ *Discover* ❑ *Check #* _____ *Amount* _____ *CC Exp Date* _____

Card Holder _____ *CC #* _____ *Billing Zip Code* _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:

I give consent for treatment and request that payment of authorized Medicare and other benefits be made on my behalf to DME Supplier, Inc. for products and services that they have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents or others, any information needed to determine these benefits or compliance with current healthcare standards.

___ My "Bill of Rights" and my responsibilities
___ My privacy notice
___ Supplier Standards
___ My right to refuse treatment
___ How to reach DME Supplier, Inc. 24 hours a day, seven days a week
___ I received the above listed equipment and have demonstrated proper use of equipment
___ I have received instruction on proper use, troubleshooting, potential hazards of equipment.
___ DME Supplier will honor all manufacturer's warranties.
___ Community resource and home safety information.

Patient or Authorized Representative Signature _____ Date _____

Relationship to Patient / Reason for Signing _____

REP SIGNATURE	DELIVERED BY	FACILITY CODE

White – DME Supplier Copy Pink – Patient Copy