alliance DME
medical supply

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SALESMAN: _____

SET UP BY: _____

PRESCRIPTION AND PATIENT AGREEMENT

~ PLEASE COMPLETE *ALL* SECTIONS OR ATTACH PATIENT DEMOGRAPHIC FORM ~

PATIENT INFORMATION
Name_____
Address_____
_____
Home Phone (_____)_____ DOB ____/____/____
Work Phone (_____)_____ Female ❑ Male ❑
Employer_____
Emp. Address _____
_____
Social Security #_____

INSURED INFORMATION (if not patient)
Insured's Name_____
Permanent Address_____
_____
Social Security #_____
Employer_____
Address_____
_____
Work Phone (_____)_____
Relationship to Patient_____

INSURANCE INFORMATION
Insurance Co._____
Address_____
_____
Phone (_____)_____
ID #_____
Group #_____
Claim # (WC)_____
Contact_____

COVERAGE TYPE
WC ❑ HMO ❑
MC ❑ PPO ❑
SELF-PAY ❑
Other_____

SECOND INSURANCE INFORMATION
Insurance Co._____
Address_____
_____
Phone (_____)_____
Insured's Name_____
ID/Group #_____

MEDICARE INFORMATION
_____
Name on Card_____
Medicare #_____
Date of Surgery_____
Discharge Date from Hospital_____
Date CPM Applied in Hospital_____

MEDICAL INFORMATION
Physician_____
Diagnosis_____
Date of Injury (REQUIRED FOR WC)_____
Diagnosis ICD-9 Codes _____
Address_____
_____
Phone (_____)_____
Length of need ❑ 1-3 mos. ❑ 3-6 mos. ❑ 6+ mos. ❑ Purchase

PRODUCT DESCRIPTION / RX

EQUIPMENT INFORMATION

MODEL	SERIAL #	EST # OF DAYS	RATE

PURCHASE INFORMATION

MODEL	QTY	PRICE EA.	TOTAL

ORDERING PHYSICIAN ***(signature required)*** _____ **DATE** _____

MEDICARE ASSIGNMENT FOR COVERED SERVICES

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf to ALLIANCE DME AND MEDICAL SUPPLY. I am 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, surgical stockings, and spinal brace soft interface obtained from ALLIANCE DME AND MEDICAL SUPPLY. I understand that because these items are excluded from Medicare coverage, that it will be subsequently billed to my secondary insurance carrier, if applicable. _____ INITIALS

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I hereby authorize that payment for medical service(s) be made directly to ALLIANCE DME AND MEDICAL SUPPLY. I represent that I have insurance coverage and do hereby authorize ALLIANCE DME AND MEDICAL SUPPLY to release and obtain all information necessary to secure payment of said benefits. _____ INITIALS

TERMS AND CONDITIONS

I understand that if my insurance fails to pay ALLIANCE DME AND MEDICAL SUPPLY in full, I am responsible for the unpaid balance. _____ INITIALS

If litigation is instituted to collect any unpaid balance, I agree to pay all costs, including reasonable attorney's fees, incurred by ALLIANCE DME AND MEDICAL SUPPLY. I have read and agree to the terms and conditions stated above. _____ INITIALS

_____ _____ _____
Patient or Guardian Signature *(Signature required)* Relationship to Patient Date