Precert Form

17 Charles St
Binghamton, NY 13905
800-485-9717 ♦ 607-584-5560
Fax: 607-584-5561

FAX this completed form with prescription & insurance card to 607-584-5561

Date:_________________
Clinic Name:______________________________
Clinic Contact:____________________________
Clinic Phone: _____________________________
Call w/ status to: □ Clinic □ Patient

Unit to be shipped:___________________________
To: □ Clinic □ Patient
Address: ___________________________________
City: _________________ State: ____ Zip: ______
Phone Number: ______________________________

Patient's Social Security: ___________________
Patient's Name: ____________________________
Address: _________________________________
City: ________________ State: ___ Zip: _______
Home Phone: ______________________________
Date of Birth: ____/___/______ □ Male □ Female

Date of Injury: _____/______/________
Employer: ___________________________________
Address: ____________________________________
City: _________________ State: ____ Zip: _______
Work Phone: _________________________________

Type of Claim:
□ W/C □ Group Insurance □ Auto
□ HMO □ Medicare □ Self-Pay
Patient's Relationship to Insured:
□ Self □ Spouse □ Child
Insured's Name: ____________________________
Insured's SS #________________DOB__/___/___

Primary Insurance:__________________________
Address: ____________________________________
City: _________________ State: ____ Zip: _______
Phone: ______________________________________
Policy # _________________ Group # ___________
Claim # _____________________________________
Adjuster Name: ______________________________

Prescribing Physician:_______________________
Physician's Clinic: __________________________
Phone: ______________Fax:_________________

Dispensing Clinic Address: ____________________
City: __________________State:____ Zip: _______
Phone:_________________ Fax: _________________

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits to Rehab Supply for services furnished. I authorize the release of any medical information required to process an insurance claim on my behalf. I permit a copy to be of the authorization to be as valid as the original. All costs of the device and supplies not paid for by insurance company will become my responsibility.

PATIENT NAME (print) ____ DATE ___________________________

PATIENT / GUARDIAN – please sign **X**____

WORKER'S COMPENSATION: RIGHT TO CHOOSE

The equipment I received is the equipment ordered by my authorized physician, and was supplied by Rehab Supply. I choose this particular equipment and this particular company. I choose Rehab Supply as my provider of my own volition. My insurance carrier may NOT change the equipment or company providing these services without my prior knowledge and approval. I choose to have Rehab Supply as the provider of any future supplies and accessories.

PATIENT NAME (print) ____ DATE ____________________________

PATIENT / GUARDIAN – please sign **X**______________________________