17 Charles Street, Binghamton, NY 13905 - Phone: (800)485-9717
Fax request to (607)584-5561

Referral Information

Clinic Name_____Contact Person_____

DME Device Request

☐ TENS
☐ TENS/ IF COMBO
☐ EMS
☐ TWINSTIM
☐ INTERFERENTIAL
☐ CONDUCTIVE GARMENT
BODY PART _____

☐ LSO BRACE
☐ KNEE BRACE
☐ WRIST BRACE
☐ ANKLE BRACE

☐ SHOULDER BRACE

☐ CERVICAL TRACTION

Anticipated length of need 99 months or _____months

Unit Training provided by: _____

********************Prescription should be included with Authorization Request********************

Once eligibility checked patient will be called if any financial responsibility. Unit will be shipped to patient's home via UPS.

Rental/Sales Agreement /Assignment of Benefits/Release of Information

Patient Contact Information

Last Name_____First Name_____Middle Name _____DOB_____

Street _____City_____State_____Zip_____

Home Phone #_____Cell Phone #_____E-mail _____

Mailing address (if different than above) _____

Emergency Contact _____Relationship: _____Phone#_____

Patient Insurance Information *(include copy of cards whenever possible)*

Primary Ins. Carrier_____Phone #_____Policy/Claim# _____

Street _____City_____State_____Zip_____

Secondary Ins. Carrier _____Phone #_____Policy/Claim# _____

Street _____City_____State_____Zip_____

Below information must also be included for Work Comp/Auto Insurance ****SSN IS REQUIRED FOR COMP CASES***

Date of Injury_____State of Accident (Auto) _____Employer (WC): _____

Social Security #_____Adjustor/Case Mgr. Name_____ Phone #_____

Patient Acknowledgment that all the information is complete & accurate

I hereby acknowledge that I agree with the 10 points of the Rehab Supply Patient Awareness Sheet provide under separate cover. I have received Rehab Supply's Important Client Information & Right Sheet that details my Bill of Rights, Notice of Privacy Practices, CMS Supplier Standards, and Rehab Supply Payment & Return Policies. If I have any questions, I may contact Rehab Supply at 800-485-9717 ext. 231 or 228. I have filled in all the patient information and written "none" in any empty space. I have been trained on it use.

Patient Signature _____**Date** _____

Guarantor/Legal Representative _____ Date _____
(Required if patient is unable to sign or under 18 yr. of age)