

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	□ LSO BRACE	\Box (CERVICAL TRACTION
☐ TENS/ IF COMBO	□ KNEE BRACE		ELKVIONE TRACTION
□ EMS	□ WRIST BRACE		
☐ TWINSTIM	\square ANKLE BRACE		
□ INTERFERENTIAL			
\square CONDUCTIVE GARMENT	☐ SHOULDER BRACE	E	
BODY PART	<u></u>		
Ar	ticipated length of need 99 months of	ormonths	
Unit Training provided by:			
*********	Prescription should be included witl	n Authorization Request**	******
Once eligibility checked nation	will be called if any financial respon	sihility Unit will be shinn	ed to natient's home via LIPS
once engionity encered patient	will be called it any financial respon	sibility. Offic will be simpp	ed to patient 3 nome via or 3.
Rental/Sale	s Agreement /Assignment of E	Senefits/Release of In	<u>formation</u>
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	Relati	onship:	Phone#
<u>Patient Insurance Information</u>	include copy of cards whenever poss	ible)	
Primary Ins. Carrier	Phone #	Policy/Cla	im#
Street	City	State	Zip
Secondary Ins. Carrier	Phone #	Policy/Cla	im#
Street	City	State	Zip
Below information must also be in	<u>icluded for Work Comp/Auto Inst</u>	urance ****SSN IS RE	QUIRED FOR COMP CASES****
Date of InjuryState	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 Rehab Supply's Important Client Informati Rehab Supply Payment & Return Policies. patient information and written "none" in	e 10 points of the Rehab Supply Patient A on & Right Sheet that details my Bill of R If I have any questions, I may contact Re	wareness Sheet provide unde ghts, Notice of Privacy Practi hab Supply at 800-485-9717 (ces, CMS Supplier Standards, and
Patient Signature			Date
Guarantor/Legal Representative			Date
Guarantor/Legal Representative	(Required if patient is unable to sign or	under 18 yr. of age)	

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