17 Charles Street, Binghamton, NY 13905 - Phone: (800)485-9717
Fax request to (607)584-5561 or (607)772-2455

Pre-Authorization Request

Referral Information

Clinic Name________________________ Contact Person________________________

DME Device Request

☐ TENS
☐ TENS/ IR COMBO
☐ EMS
☐ TWINSTIM
☐ INTERFERENTIAL
☐ CONDUCTIVE GARMENT
BODY PART ____________________

☐ LSO BRACE
☐ L0642 ☐ L0648
☐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 226. 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)

CONFIDENTIAL
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