Patient Information Sheet

Patient Name:

____

Patient Address:

____

____

(City) (State) (Zipcode)

Patient Phone: (______)_____-_______ Birthdate: ____/______/______ Sex: M F

Social Security # _____-_________-________

Primary Insurance: (Name/Address)

____

Primary Policy Number: ____________________ Phone Number:

____

Supplemental Insurance: (Name/Address)

____

Supplemental Policy Number: ________________ Phone Number:

____

Are you presently residing at home? Y N Nursing Home? Y N

I authorize release of any information necessary to process this claim and request that payment of all government or private benefit's be made to myself or to the party who accepts assignment for the services listed below. In addition, my signature indicates that I received all services as prescribed by my physician. I understand should my insurance not make appropriate payment nor cover items dispensed, I will be personally responsible for payment.

Signature of patient or guardian: ________________________________ Date:
___/___/___

PRESCRIBING PHYSICIAN: ___________________________________ UPIN:

____

PRESCRIBING PHYSICIAN'S ADDRESS:

____

____NPI :__________

____

(City) (State) (Zip Code)

PHYSICIAN'S PHONE: (_____) _______-__________ FAX: (_____) ______-

____

____ Follow-up letter to Doctor (sent ___/___) _____ Include product info.
____ Bill Insurance (submitted ___/___) _____ Send Directions
____ Call for Rx/CPS/Diag. Code _____ Call for Prior Approval

Patient Information Sheet

____ ORIGINAL RX ON FILE ____ SIGNED C.P.S. ON FILE

DATE OF SVC:	HCPCS CODE:	DESCRIPTION:	CHARGE:
NO. DISP.			
_____________	______________	_____________________________	_$_______.____
________			
_____________	______________	_____________________________	_$_______.____
________			
_____________	______________	_____________________________	_$_______.____
________			
_____________	______________	_____________________________	_$_______.____
________			

TOTAL PRODUCT CHARGES _$_______.____

ASSIGNED: YES NO SALES TAX: _$_______.____

DIAGNOSES: _______ ______ ______ ______ TOTAL DUE: _$_______.____

TOTAL PAID BY PATIENT: _$_______.____

____ Follow-up letter to Doctor (sent ___/___) _____ Include product info.
____ Bill Insurance (submitted ___/___) _____ Send Directions
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