Pro Medical East
A GARDEN STATE MEDICAL SUPPLY COMPANY

BRACE REQUEST / AUTH TO BILL

CUSTOMER SERVICE AGREEMENT, AUTHORIZATION FOR PAYMENT, RELEASE OF INFORMATION, AND CUSTOMER INFORMATION

PLEASE SUBMIT WITH PATIENT FACESHEET

DATE _____

PATIENT INFORMATION

FACILITY NAME _____ FACILITY ADDRESS _____

REQUESTER (DOR/PT/OT/OTHER) NAME _____

PATIENT NAME _____

IS RESIDENT ON A SKILLED NURSING STAY? ☐YES ☐NO IF YES, WHAT IS THE EXPECTED DISCHARGE DATE?_____

ITEM INFORMATION

ITEM _____ SIZE _____ ☐RIGHT ☐LEFT ☐BOTH

CATALOG USED _____ UNDERLYING CONDITION (S) _____

I am requesting this brace based on my recommendations and diagnosis listed above. I will fit and adjust the brace, if needed, on behalf of Pro Medical East or any of its affiliates.

REQUESTER (DOR/PT/OT/OTHER) SIGNATURE _____ DATE _____

I request that payment of authorized Medicare/Medicaid or other private insurance benefits be made on my behalf for products/services furnished to me by Pro Medical East or any of its affiliates.

I authorize the release of medical information and records to the Center for Medicare and Medicaid Services (CMS), its Agents, third party payers or other parties necessary within the ordinary course of ensuring compliance with applicable quality of care, licensure or accreditation standards. I further authorize release of any information to other persons (only as authorized by law) needed to determine these benefits payable for related services.

I understand that I am financially responsible for any charges not covered by other payers (Medicare/Medicaid and/or other insurances), including but not limited to the following:

- Annual deductible (if not met)
  - Medicare annual deductible for 2019 is $185.00.
- Coinsurance
  - Medicare will cover 80% of the approved allowable charge. I am responsible for the 20% co-payment (if not covered by other payor sources.)
- Co-payments cannot be waived unless financial hardship is determined.
- Rental/purchase price for equipment and/or supplies (if not covered by present insurance).
- If I receive payment directly from an insurance company for products provided by Pro Medical East, it is my responsibility to forward payments and statements of paid services to them.

I may request a detailed statement of my account at any time by contacting the billing department at 732-657-9600.

I further verify that I have received information containing: Customer Bill of Rights and Responsibilities, Medicare Supplier Standards, General and emergency contact information, Customer Satisfaction Survey, HIPAA Privacy Notice, Capped Rental Information (Medicare Rentals), Company Grievance Process, Home and equipment safety information, equipment cleaning instructions (if applicable), prevention of infection, warranty information, the scope of services provided and possible associated fees. I understand my option to purchase or rent applicable DME items.

SIGNATURE

PATIENT SIGNATURE* _____ DATE _____

RELATIONSHIP (IF NOT CUSTOMER) _____ DATE _____

**if patient is unable to sign, please have the Admin/DON/DOR or POA sign, with their title and reason why patient is unable to sign*

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