



A Division of Compex Technologies, Inc.
P. O. Box 30244
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(800) 343-0488
Corporate Fax: (800) 272-6458
www.rehabiliticare.com

Precert Form

Please FAX this completed form, Rx form and Patient's insurance card to the fax number listed below. If no fax number is listed, fax form to Corporate fax number:

Date: _____ Clinic Contact: _____ Clinic Phone Number: _____ Call with status to: <input type="checkbox"/> Clinic <input type="checkbox"/> Patient <input type="checkbox"/> Rep. Rep. Name: _____	Unit Type To Be Shipped: _____ To: <input type="checkbox"/> Clinic <input type="checkbox"/> Patient Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____
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Patient's Social Security #: _____ Patient's Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Birth Date: __ __ __ <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Injury: _____ / _____ / _____ Employer: _____ Address: _____ City: _____ State: _____ Zip: _____ Work Phone: _____
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Type of Claim: <input type="checkbox"/> W/C <input type="checkbox"/> Group Insurance <input type="checkbox"/> HMO <input type="checkbox"/> Self-Pay <input type="checkbox"/> Medicare <input type="checkbox"/> Auto Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Insured's Name: _____ Insured's SS#: _____	Primary Insurance: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Policy #: _____ Claim #: _____ Group #: _____ Group Name: _____ Adjuster Name: _____
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Prescribing Physician: _____ Physician's Clinic: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Dispensing Clinic: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
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Patient Signature Required For Assignment Of Benefits:

I hereby authorize payment of medical benefits to Rehabiliticare, A Division of Compex Technologies, Inc. for services furnished. I further authorize the release of any medical information required to process an insurance claim on my behalf. I permit a copy of the authorization to be as valid as the original. All costs of the device and supplies not paid for by my insurance company will become my responsibility.

Print name: _____ Date: _____

Patient's Signature: _____
(Parent or Guardian Signature if under 18 yrs. old) *(electronically fabricated signature not acceptable. Patient required to sign printed copy of form OR sign tablet PC screen with form image.)*

Worker's Compensation: Right to Choose

The equipment I received is the equipment ordered by my authorized physician, and was supplied by Rehabiliticare, A Division of Compex Technologies, Inc.. I choose to use this particular equipment and this particular company. I choose Rehabiliticare as my provider of my own volition and understand that I have this right if applicable under the worker's compensation law in the state of my residence. My insurance carrier may NOT change the equipment or company providing these services without my prior knowledge and approval. I choose to have Rehabiliticare as the provider of any future supplies and accessories.

Print name: _____ Date: _____

Patient's Signature: _____
(electronically fabricated signature not acceptable. Patient required to sign printed copy of form OR sign tablet PC screen with form image.)