Medsource, Inc
400 Rhode Island Ave
Fall River, Massachusetts 02721
Tel: (508) 646-4556
Fax: (508) 646-4743

NAME ______ **ADDRESS** ______
CITY ______ **STATE** ______ **ZIP** ______ HOME PHONE: ( ) ______
BIRTH DATE ______ **SOCIAL SECURITY #:** ______ MARITAL STATUS: S / M / D / W **GENDER: M / F**

PRIMARY POLICY HOLDER & INSURANCE INFORMATION

PC BCH BCBS AETNA MCR MCD *WC *MVA ****OTHER:*** *INS CO NAME* ______

PHONE ______ ADDRESS ______ CITY ______ STATE ______ ZIP ______

ID#:______ **SUFFIX:**______ *(include alpha prefix for Blue's, alpha suffix for Medicare, and two digit suffix for all HMO's)*

IS THE PATIENT THE POLICYHOLDER? YES or NO ***If no, continue below.***

NAME ______ ADDRESS ______
CITY ______ STATE ______ ZIP ______ HOME PHONE ( ) ______ SEX: M / F
BIRTH DATE ______ SOCIAL SECURITY # ______ RELATIONSHIP TO PATIENT: ______

SECONDARY POLICY HOLDER & INSURANCE INFORMATION

PC BCH BCBS AETNA MCR MCD *WC *MVA ****OTHER:*** *INS CO NAME* ______

PHONE ______ ADDRESS ______ CITY ______ STATE ______ ZIP ______

ID#:______ **SUFFIX:**______ *(include alpha prefix for Blue's, alpha suffix for Medicare, and two digit suffix for all HMO's)*

*** WC & MVA MUST COMPLETE ALL FIELDS BELOW!**

INSURANCE COMPANY NAME ______ Adjuster's Name ______
ADDRESS ______ CITY ______ STATE ______ ZIP ______ PHONE ( ) ______
DATE OF INJURY ______ WC# ______ CARRIER CASE # ______

PRESCRIBING INFORMATION (REFERRAL) & PATIENT NOTES (CLINICAL)

PHYSICIAN NAME ______ **Please attach LMN / Invoice / Prescription!**
DATE OF SURGERY:______ PLACE OF SURGERY:______ **BRACE: Mailed / Delivered (patient must sign below)**
COMMENTS:______

______

MEASUREMENTS:______

DIAGNOSIS OR ICD-9 CODE(S): 1)______ 2)______ **CHARGES OR CPT CODE(S): 1)**______ 2)______

BENEFITS ASSIGNMENT

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any information necessary to process an insurance claim for services rendered on my behalf. I understand that I am responsible for all "out of network" (copayment/coinsurance/deductible) charges, and agree to pay for all services and supplies not paid by my insurance company within sixty (60) days. I also authorize the above insurance companies to pay my benefits directly to Medsource, Inc for medical services rendered to me. Copies of this authorization shall be valid as the original.

Patient or Authorized Signature:______ **Date of 1st Appointment:**______

DELIVERY AND ACCEPTANCE

I further acknowledge that I have received a copy of the "21 Supplier Standards" and HIPAA Disclosure Statements. All products are covered with a 1 year warranty from date of delivery. All repairs/replacements will be made for product defects free of charge up to one year.

Patient Receipt (copy) "Proof of Delivery":______ **Date of Delivery (Claim):**______