

CLIENT AUTHORIZATION AND PLAN OF SERVICE

CLIENT NAME _____	DOB _____ / _____ / _____
ADDRESS _____	
CITY _____	STATE _____ ZIP _____
EMERGENCY CONTACT _____	PHONE NUMBER _____
PHYSICIAN _____	PHONE NUMBER _____
DIAGNOSIS _____	
PRODUCTS ORDERED _____	
MEDICARE PART B NUMBER (IF ELIGIBLE) _____	EFFECTIVE _____
MEDICAID NUMBER (IF ELIGIBLE) _____	STATE _____
OTHER INSURANCE _____	
ADDRESS _____	
POLICY NUMBER _____	GROUP NUMBER _____
POLICY HOLDER _____	DOB _____

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to Pumps It, Inc for equipment / supplies that were furnished to me for which they bill you on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to the above named company, any and all information which will assist in processing my claims for medical supplies and/or equipment that I am receiving from the above named company even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above named company any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for services and supplies that I have received, rather than directly to the above named company, I agree to endorse those checks and send them immediately to the above named company.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under Pumps It, Inc financial hardship program.

I hereby agree that Pumps It, Inc or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received the products ordered. I have received a copy of a client handout that contains client rights and responsibilities, supplier standards, privacy notice and emergency information. I have received the product manual/instructions, warranty information, and instructions to follow up with Pumps It, Inc.

I understand that items prescribed for home care cannot be re-dispensed. Therefore, these items cannot be returned for credit.

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

Identified needs/problems: The client was unfamiliar with use of the product(s) provided. Expected outcomes: The client will be provided the product(s) to comply with the physician's prescription. The client will use the product(s) as prescribed by the physician. The client will know how to obtain follow-up services as needed.

CLIENT OR RESPONSIBLE PARTY SIGNATURE: X _____ DATE: _____ / _____ / _____

IF BENEFICIARY IS UNABLE TO SIGN:

WITNESS SIGNATURE / RELATIONSHIP: _____

REASON CLIENT UNABLE TO SIGN: _____