 **Insurance**

**Please indicate which insurance is primary and/or secondary and make certain**

**Allen Orthotics & Prosthetics has copies of your insurance cards.**

**Primary Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Address/City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Relationship to Patient: □ Self □ Spouse □ Parent □ Guardian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Address/City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Relationship to Patient: □ Self □ Spouse □ Parent □ Guardian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare or Medicare Advantage Insurance**

1. Do you currently reside in a skilled nursing facility? □ No □ Yes, Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Have you ever received the same or similar supplies/services? □ Yes □ No

If yes, list the equipment / supplies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was it purchased? \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ who was it purchased from? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the item returned to the original supplier? □ No □ Yes, Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the item being replaced? □ Yes □ No Is there a new medical necessity? □ Yes □ No

3. May we contact you by phone concerning Medicare-covered items and services? □ Yes □ No

**CMS Supplier Standards for Medicare Beneficiaries and Assignment of Benefits**

I acknowledge that I am a Medicare beneficiary and have been given an opportunity to obtain and review a copy of the Supplier Standards. The products and/or services provided to you by Allen Orthotics & Prosthetics, Inc. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at <http://ecfr.gov>. Upon request, we will furnish you with a written copy of these standards.

I request that payment of authorized Medicare, Medicaid, or Private Insurance benefits be made either to me or on my behalf for any services furnished to me by Allen Orthotics & Prosthetics, Inc. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents or to the appropriate Private Insurance Company any information needed to determine these benefits or benefits for related services.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Patient / Responsible Person’s Signature** **Date**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient** Internal use – received/reviewed by: \_\_\_\_\_\_\_\_