

CLIENT APPLICATION



PATIENT INFORMATION

Patients Name _____ **Date of Birth** ____/____/____
Street Address _____ **City** _____ **State** _____ **Zip** _____
Ship To Address _____ **City** _____ **State** _____ **Zip** _____
Telephone _____ **E-mail** _____ **Male** ___ **Female** ___

INSURANCE INFORMATION

Primary Insurance

Medicare Claim Number _____

Name as written on Red/White/Blue Medicare Card:

Secondary Insurance

Does the patient have secondary insurance? _____

Insurance Company _____

ID number _____

****Are you signing up for a new plan today? Y N

Company: _____

Effect. Date: _____

PRESCRIBING PHYSICIAN INFORMATION

Name _____ **Clinic** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Telephone _____ **Fax** _____ **Date of Last Visit** _____

NPI# _____ **UPIN** _____

MEDICAID # _____

SUPPLIES INFORMATION

Current Supplier _____ **Date Last Received Supplies** _____

Diabetic

Regular Heating Pad

Ed Pump

Diabetic Supplies

Arthritis

Heating pad w/pump

Thermoskin Wrap

ED Pump

Mobility

Scooter

Power Wheelchair

Beneficiary Signature

Date

*By filling out this form, I authorize Relief Health Services and/or any of it's affiliates to contact me regarding the coordination of shipment and/or the furnishing of a Medicare covered item that is to be rented or purchased.

WRITING AGENT

*Must complete all red fields