

Sales: 800-800-9295
Fax 586-469-1392

MedCare Service

18822 Monica Clinton twp., MI 48036
Business Hours are 9:00 to 5:00

Unit No _____
Rec. No Elect _____ Batt _____
Date of appointment _____

Physician Prescription form

Patient's Demographics

M [] F []

Last Name _____ First Name _____

Patients Address _____

Home Phone _____

BirthDay _____ Date of injury _____

Employer _____

PRIMARY INSURANCE

Prior Authorization Number: _____

Insurance verification given by : _____

Date of Verification : _____

Insurance Company _____ Telephone Number _____

Contract Policy Number _____

Insurance Company Address _____

Insured Name _____ Birthday _____

Social Security Number _____

Employer _____

SECONDARY INSURANCE AND OR ATTORNEY INFORMATION

Insurance Company _____ Telephone Number _____

Contract Policy Number _____

Insurance Company Address _____

Insured Name _____ Birthday _____

Social Security Number _____

Employer _____

When the monthly Supplies are no longer needed the patient is
Required to call and request they stopped.

Muscle Stimulator With Monthly Supplies

Conventional TENS 4 Lead and Monthly Supplies

Conventional TENS 2 Lead and
Monthly Supplies

MicroCurrent Electrical Nerve Stimulator
(M.E.N.S.) With Carrier Frequency 10,000 Hz Modulated
Frequency 9.1 Hz & 292 Hz.
With Monthly Supplies

Authorizing Physician: _____

Physician's Address _____

Phone _____

License. # _____ NPI #: _____

Reason for Medical Necessity _____

Diagnosis _____

Diagnostic code _____ Treatment Duration _____

Authorizing Physician's Signature _____ Date _____
Dispense As Written

I Agree that the rental equipment remains the property of the pro-
vider and will be returned to them in good condition when no longer
medically necessary.

I request that payment of authorized Medicare, Medicaid or other
private insurance benefits be made directly to the provider for any
services furnished me by that supplier. I authorize any holder of
medical information about me to release to the MedCare Service and
its agents, any information needed to determine those benefits or the
benefits payable to related services.

I have read and understand the MedCare Service. terms and proce-
dures and I agree to pay any unpaid balance incurred by my use of
the Electro stimulator.

HIPPA Products Education Written Instruction

Warranty Home Safety Rent Purchase Option Letter

Patients Rights & Responsibilities Medicare Supply Std.

I have received the product listed above, I have been informed of the items
checked above and I have received the written items checked above.

Patients Signature _____ Date _____