Hope MEDICAL SUPPLY, INC.

1-800- 251-4673
VEDPUMPS.COM

VED ORDER FORM

Patient: _____ Ht: _____Wt: _____DOB: ____/ ____/ ____ SS # : _____ /____ / _____

Address/City/State/Zip: _____Phone: _____

Primary Ins: _____ Policy #: _____Group#:_____Phone: _____

Secondary Ins: _____ Policy #: _____Group#:_____Phone: _____

Customer Orientation Checklist *(See Orientation Materials posted on VEDPumps.com, copies of which will be provided with your delivery)* I have received, read and/or been instructed on: ❑My rights and responsibilities as a customer; ❑My Concerns Form and Customer Satisfaction Survey; ❑Safe use, proper fitting and operation of the equipment delivered; ❑Written instructions and training regarding the proper use, cleaning and maintenance of equipment and supplies; ❑Written materials containing: Products and services, company telephone numbers; Hope Medical Supply's policy on Warranty, Financial Obligation; Notice of Privacy Practices (NPP) (HIPAA Notice); and Medicare Supplier Standards.

Assignment of Insurance Benefits I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered services rendered by Hope Medical Supply, Inc. to Hope Medical Supply, Inc. and authorize Hope Medical Supply, Inc. to submit claims to my insurance for payment. I authorize payment of my insurance benefits directly to Hope Medical Supply, Inc.. I hereby guarantee payment to Hope Medical Supply, Inc. of any and all charges not covered by this assignment, and waive any and all notices and demands in the event of non-payment there under.

Release of Information I hereby authorize the holder of medical or other information about me to release to the Social Security Administration, Center for Medicare and Medicaid Services, its intermediaries or to any third party payer, or to any medical provider, as required, any information needed for this or a related health claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I also authorize release of medical information to my physician(s), other health care Providers to assist in my treatment, utilities companies to assist in my care in the event of an emergency, auditors authorized by Hope Medical Supply, Inc. for the purpose of certification, licensure or accreditation.

Financial Responsibility I understand that any charges not paid for by my health insurance are my financial responsibility. I agree to pay Hope Medical Supply, Inc. any deductible and co-pay or other amounts due for home medical equipment and/or supplies provided by Hope Medical Supply.

X_____**Date:** _____

Patient Signature

Physician Orders

I prescribe a Vacuum Erection Device (VED) HCPC: L7900. The patient's erectile dysfunction is:

❑Carcinoma of Prostate (185)
❑Carcinoma of the Bladder (188.9)
❑Peripheral Vasuclar Disease (433.9)
❑Non-Insulin Dependent Diabetes Mellitus (250.00)
❑Insulin Dependent Diabetes Mellitus (250.01)
❑Hypertension (401.9)
❑Spinal Cord Injury (952.9)
❑Colo-Rectal Cancer (154)
❑Other: _____

Length of Need:_____mo (99=lifetime)

X_____**Date:** _____

Physician Signature

Physician Name: _____

Address: _____

Telephone: _____

NPI: _____

Return this order form in the mail to:
Hope Medical Supply
1116 E. Houston,
San Antonio, TX 78205

or via fax toll free to:
(877) 226-1484