VED® Classic™ Axis™ Ultra™

FIRMA MEDICAL

ORDER FORM
Prescription & Financial Policies

Questions: (800) 771-9263, ext. 101
Please fax to: (817) 473-9639

Physician Information

I have prescribed the Battery Operated Therapy System (L7900). It is my expert opinion that a vacuum device is medically necessary to facilitate management of this patient's sexual dysfunction. This prescription will also serve as the Letter of Medical Necessity. Dispense as written. Estimated length of need is 99 months (lifetime).

Diagnosis
____607.84 Organic ED
____952.9 Spinal Cord Injury
____250.01 Insulin Dependent (Diabetes Mellitus)
____185 PCA
____Other _____

Physician's Name _____ UPIN# _____

Address_____Phone_____

City _____ State _____ Zip Code _____

Physician's Signature_____ Date _____

PATIENT INFORMATION (Please print and fill out entirely)

Full Name _____ DOB _____/_____/_____

Address _____

City, State, Zip _____

Home Phone _____ Alt Phone _____

Email_____

(*Physician's offices can certainly fax a copy of the patient's face sheet to give us more information)

INSURANCE INFORMATION- *Please include copies of the front & back of ALL insurance cards listed below*

PRIMARY INSURANCE _____ POLICY ID# _____ PHONE _____

GROUP ID#_____

SECONDARY INSURANCE _____ POLICY ID# _____ PHONE _____

(MEDICARE patients please include your secondary insurance if available. Our company does not contract with any secondary insurance carriers but most secondary insurance companies will pay if Medicare pays as a primary payor.)

Authorization to Assign Benefits

PERSONAL HEALTH INFORMATION - Please read the Firma Medical Patient Privacy Practices outlined on the back.
I hereby request payment of my authorized carrier to be made on my behalf to Firma Medical for products and services that they have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to release any such information to any other insurance company and/or their agents to determine benefits. I understand that Firma Medical bills third-party payors as a courtesy and I am fully responsible for all deductibles, co-insurance and disallowables. **By my signature below, I agree to authorize to assign benefits and to all financial policies outlined above. I have also read and understand and accept Firma Medical's Notice of Privacy Practices.**

_____ _____

Patient Signature **Date**

Firma Medical, 99 Regency Pkwy, Ste. 203, Mansfield, Texas 76063 **office (817) 473-7473 fax (817) 473-9639**