USMED

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★★ All information MUST be ★★ completed in order to process

FAX Completed Form to: 1-888-919-1729 • Questions? Call: **1-800-809-3472**

BLIND DIABETES ENROLLMENT FORM

Name of person completing form: ____________________ Phone: (____) ____________

PATIENT INFORMATION

Name: ____________________ Phone: (____) ____________

Address: ____________________ Apt. / Room #: ____________

City: ____________ State: ________ Zip: ____________

DOB: ____ /____ /____ Sex: ❑ Male ❑ Female Language: ❑ Spanish ❑ English ❑ Other: ________

INSURANCE

Primary Company: ____________________ Policy #: ____________

Phone: (______) ____________ Pharmacy Rx Bin #: ____________

Secondary Company: ____________________ Policy #: ____________

Phone: (______) ____________ Self Pay? ❑ Yes ❑ No

DIABETIC SUPPLIES

Using insulin injections? ❑ Yes ❑ No ______ # Times testing per day? Preferred meter? ☑ Prodigy Voice (Totally Audible)

PHYSCIAN INFORMATION

Physician's Name: ____________________

Phone: (_____) ____________________

Fax: (______) ____________ NPI: ____________

AUTHORIZATION

US MED consists of United States Medical Supply, LLC, US MED, LLC and related companies.

- I acknowledge initiating contact with US MED to receive my CPAP supplies as authorized by my physician.
- I authorize US MED, to contact my doctor, as well as Medicare, Medicare Supplement, Medicaid or commercial insurance for the release of medical and other information necessary to obtain the products I am requesting.
- I authorize US MED, to file all paperwork and submit a claim on my behalf.
- I authorize US MED, to accept assignment on my behalf for any claims submitted to Medicare, Medicare Supplement, Medicaid and commercial insurance for any products, items or services and all reimbursements shall be paid directly to US Med. I agree that if my insurance company sends me the payments, I will send all of the payments and statements of benefits received, immediately to US MED.
- I authorize US MED, to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.
- I understand that this Assignment of Benefits will be effective for any current or future claims unless I or a representative on my behalf revokes the assignment.

Patient Signature: ____________________ Date: ____________

Printed Name: ____________________

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