INSERT LETTERHEAD HERE

Payment Authorization

Date: _____

Patient Name: _____ DOB _____ I have received and been appropriately been informed on how to properly use the wound care products listed:

____ unit(s) (A6010) Collagen based wound filler, dry form, sterile, per gram of collagen

____ unit(s) (A6021) Collagen dressing, sterile, size 16 sq in or less, each

___ unit(s) (A6196) Alginate or other fiber gelling dressings, wound cover, sterile, pad size 16 sq in or less, each dressing ____ unit(s) (A6197) Alginate or other fiber gelling dressing, wound cover, sterile pad size more than 16 sq in but less than or equal to 48 sq in, each dressing

____ unit(s) (A6219) Gauze, Non-Impregnated, Sterile, Pad Size 16 Aq. In. Or Less, With any size adhesive border, each dressing

____ unit(s) (A6220) Gauze, non-impregnated, sterile, pad size more than 16 sq in, but less than or equal to 48 sq in, with any size adhesive border, each dressing

60 unit(s) (A6402) Gauze, Non-Impregnated, Sterile, Pad Size 16 Aq. In. Or Less, without adhesive border, each dressing

1 unit(s) (A6260) Wound cleanser, any type, any size

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to the organization listed above for any equipment or services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization. I understand that I am responsible for the entire bill, any deductible, and/or co-insurance if my insurance carrier fails to pay. If I have insurance other than Medicare (including secondaries), I understand that I am responsible for any payments that are not covered by my insurance.

Initials:

_____ I agree that this product is medically necessary for my condition and I am satisfied with the product. I acknowledge that I have the potential to benefit from using this DME. Use and care of this product was discussed. Opportunity for questions about this product was offered and all my questions answered.

_____ I have received a DME packet with printed copies of:
-Medicare DME supplier standards
-Return policy on the product dispensed

Signature of acceptance: _____ Date: _____

Witness: ________________________________ Date: _________________