Fax: (866)229-0034
Phone: (866)217-0372

Sales Rep: ~3~_____

Order Date: _____ Patient Name: _____ DOB: _____ Place of Service: _____
Address: _____ Phone: _____ Provider: _____NPI: _____
Shipment Approved by: _____ Assigned Unassigned
Insurance 1: _____ Policy #: _____ Coverage %: ____ Insurance 2:_____ Policy #:_____ Coverage%:_____

DX Codes									

Supplies Order/Provided Duration of Need (Days): ___ Number of Refills: ____

Product	Qty Still on hand	Physical Units	# to be used per change	Used on # of wounds	Frequency of change	Billable Units	Price per Billable Unit	Billed amount
~strid=91~								
								~strid=91end~

Total: _____
Est. Patient Responsibility: _____

Provider Signature:_____ Date:_____
I attest by my signature that it is my intention for this prescription to remain valid until, the underlying disease/diagnosis described above is resolved or otherwise directed by the signer.

I request that payment of authorized medical benefits be made to Impact Medical Medical Services LLC. for any covered service furnished to me. In cases where Impact Medical Medial Services LLC. agrees to accept assignment, Impact Medical Medical Services LLC. will accept the charge determination as the full charge for the covered services. I am always responsible for the deductible, co-insurance and unassigned uncovered services. I agree to pay Impact Medical Medical Services LLC. any payment made directly to me by insurance for services provided by Impact Medical Medical Services LLC. on an assigned basis. I agree that in the event my insurance or other third party payor refuses to pay the rental or purchase price of the equipment or service that I will be responsible for those payments or shall return the equipment involved. I authorize the release of any medical or other insurance information to process this claim.

_____ _____ _____
Beneficiary/Guardian Signature Date Relationship to patient/Reason patient couldn't sign Impact Medical Representative Date