

Customer Order Form

Date: _____

Customer Name: _____

Address: _____

(Physical)

(Mailing)

City: _____ State: _____ Zip Code: _____

Phone: () _____ - _____ (Home) () _____ - _____ -- _____ (Work)

() _____ - _____ (Cell)

Birthdate: _____ Height: _____ Weight: _____

Equipment Requested: _____

Payment Method: Check Money Order Visa Mastercard

(Please do not send cash)

If paying by credit card the following is needed:

Name on credit card as it appears: _____

Credit Card Number: _____

Expiration Date: _____

Signature of Patient

Date

*Page two of this order form only has to be filled out if you are requesting Eagle Home Medical to process this claim through your insurance company.

The following information is needed for insurance billing – please fill out all sections and provide a prescription from your physician with the equipment you are requesting and diagnosis (the prescription is only good for 30 days). We also need a copy of each of the insurance cards (front and back) to keep on file as a requirement of insurance companies. Once information is received a customer representative will contact you to finalize all necessary procedures.

Social Security Number: _____

Primary Insurance Company Name: _____

Policy Number: _____

Group Number: _____

Secondary Insurance Company Name: _____

Policy Number: _____

Group Number: _____

Physician's Name: _____

Address: _____

Phone: _____

Signature Authorization

I request that payment of authorized insurance benefits be made to Eagle Home Medical Corporation for any services furnished to me by that supplier. I authorize any holder of medical information about me to release to Eagle Home Medical Corporation, my insurance carrier and its agents any information needed to determine these benefits or benefits payable for related services. I authorize Eagle Home Medical Corporation to release any information to other organizations involved in delivery of my Health Care Services. I understand that I may withdraw this assignment at any time by written notice to the supplier.

Signature of Patient

Date