PRINT CLEAR FORM

MAXIMILIAN MEDICAL, LLC.
100 Commerce Way, #5, Hackensack, NJ 07601 | Phone: 201-880-7802 | Fax: 201-880-7804

DME/O&P Proof of Delivery/RX/Patient Agreement

1 Prescription

Product Bar Code Label Here

Patient First Name: MI

Patient Last Name:

Order Date: / /

2 Providers Name: (First) (Last)

Provider's NPI#:

By my signature, I am prescribing the item listed. In my judgment, the prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

3 Provider's Signature: | Date: (MUST BE ON OR BEFORE DATE OF SERVICE) / /

For Medicare: NO SIGNATURE STAMPS | For Medicare: (Initial Date of Need) / /

Length of Need:

4 Patient Diagnosis **ICD 10 Code**

REQUIRED Quantity of Item Ordered ☐1 ☐2 ☐( ) ☐RT ☐LT ☐N/A

Patient Address:

City State Zip

Phone:

Date of Birth: / /

INSURANCE INFORMATION

Name:

Address:

Date of Accident: / /

Billed Amount: $ Estimated COPAY: $

☐ This shall serve as PROOF OF DELIVERY AND AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER

L CODE: Description:

☐ Off the Shelf ☐ Custom Fitted ☐ Custom Fabricated Make and Model Number:

Services and Information on Capped Rental

- ☐ Measured Sized and Fit Patient Properly for Brace
- ☐ Discussed Goals with Patient
- ☐ Patient Understand Proper Fit and Care of Device
- ☐ Return Demonstration by Patient/ Patient Alert
- ☐ Rights and Responsibilities Given to Patient
- ☐ Medicare Supplier Standards Given to Patient
- ☐ Pt Received Scope of Services and Information on Capped Rental
- ☐ Referred Patient to Physician for Final Checkout
- ☐ Discussed Appropriate Safety Factors
- ☐ Item was Checked and is in Good Working Order
- ☐ Warranty, Infection Control Tips, Privacy Standards Given to Patient
- ☐ Cleaning Tips and Maintenance Discussed

Complaint Protocol: If you are unhappy with the services provided, please call _____. We will respond within 5 business days. In the event you r complaint is not resolved to your satisfaction, you may contact our accreditation organization THE COMPLIANCE TEAM at **www.thecompliance team.org** or by calling 8**88-291-5353**.

☐ Follow up recommended ☐ Follow up by phone and as needed

Patient Production, Education, Bill of Rights and Responsibilities: By signing below I acknowledge, authorize, and understand that Max Med LLC is the provider of the medical product(s) that I am receiving today which are prescribed by my physician. I authorize Max Med LLC and Its Representatives to deliver, teach, administer, or demonstrate as necessary the product and treatment prescribed by my physician. I have been instructed in the proper fitting and usage of the product(s) received. I understand that once the equipment has been used, it is no longer able to be returned (unless a rental item) refunded, or re-sized. I have been instructed to contact my physician for any questions or concerns related to my medical care or status. Disclaimer of Warranty: We will honor all warranties honored by the manufacturer of the product. If the product becomes defective, it is your responsibility to notify Max Med LLC immediately and its representative to resolve the issue in a timely manner. Failure to notify will lead to the missed treatments by you r physician.(you may reach Max Med at (201) 880-7802 Monday-Friday 9:00AM to 5:00 PM (Eastern Time) I hereby acknowledge that I have been given the patient manual, product warranty, package insert, return and exchange policy, and instructions on how to reach Max Med. I have also received the Notice of Privacy Practices.

Assignment of benefits (AOB) Release of Information and Estimated Patient Responsibility. By signing below, I hereby authorize Max Med LLC or its Representatives to submit a claim for such product(s) to My insurer on my behalf and assign the benefits payable to my insurer for such products. I authorize my health care provider and Max Med LLC to release medical information required by my insurer to process the claim. I understand that any patient responsibility amount provided to me by Max Med LLC or their representatives is an ESTIMATE only. If I have more coverage that written above, it is my responsibility to notify Max Med. I understand there is no guarantee of payment by my insurer and that regardless of insurance coverage; I am ultimately responsible for my bill. I further understand that the pre-authorization process is a courtesy by Max Med and its Representatives, and it is my responsibility to contact my insurer if I have questions about my potential financial obligations for the product(s). I certify by signing below that I prefer that product(s) that I am receiving/ordering are prescribed by my physician and will be billed to my insurance company by Max Med, LLC from 100 Commerce Way Hackensack NJ 07601. I request payment of authorized insurance benefits for related services to the supplier. I hereby acknowledge and understand by signing below that I am responsible for all charges for products received by me. Although I am requesting Max Med LLC and its representatives to bill mu insurance on my behalf, I understand that it is my responsibility to ensure that the claim is paid in a reasonable time. I agree to provide a credit card/debit card number for billing, if applicable, for any reason a portion of my bill is not paid by my insurance. I further agree to make arrangements for my prompt payment of my bill. You will receive a separate statement for any co-insurance, deductible, or non-covered items. A WORKERS COMPENSATION PATIENT IS NOT RESPONSIBLE OF R ANY BILL.

Patient Signature: Patient Name:

Date of Delivery: / / Date of Follow up: / /

Employee Signature: Employee Name:

ORIGINAL COPY TO MAXIMILIAN MEDICAL, LLC. YELLOW COPY TO PATIENT PINK COPY TO PHYSICIAN