Awesomfit.com

Initials



**Customer Information Insurance Verification Form**

Awesomfit Bras

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: | First Name: | | | | | Initial:\_\_\_\_\_ | DOB: | |
|  |  | | | | |  | |
| Address: | | | | | | | | |
| City: | | | | State: | | | | Zip Code: |
| Email Address: 🞏 Please add my name to your mailing list \* | | | | | | | | |
| Home Phone: | | Alternate Phone: | | | | | | |
| You may leave phone messages for me @ | | | | | | | | |
| PHYSICIAN: | | | NPI NUMBER: | | | | | |
| Phone: | | | | | | Fax: | | |
| **MEDICARE ONLY:** | | | | | | | | |
| City: | | State: | | | | | | IN PECOS? \_\_\_ YES |
| **PRIMARY INSURANCE:** | | | | | | Phone Number: | | |
| Member ID#: | | | | | | Group#: | | |
| Policy Holder: | | 🞏 Self | | | | Other: | | |
| **SECONDARY INSURANCE:** | | | | | | Phone Number: | | |
| Member ID#: | | | | | | Group#: | | |
| Policy Holder: | | 🞏 Self | | | | Other: | | |
| DATE OF SURGERY: \_\_\_\_/\_\_\_\_/ | | SURGERY SIDE: Left Right | | | | | | |
| 🞏 Lumpectomy | 🞏 Mastectomy | | | | | 🞏 Any Lymph Node Removal | | |
| 🞏 Reduction | 🞏 Reconstruction | | | | | 🞏 Other | | |
| 🞏 Chemotherapy | 🞏 Radiation Therapy | | | | |  | | |
| Any Further Breast Surgery Type: | | Date: \_\_\_\_\_\_\_ | | | Prognosis: | | | |
| I HAVE RECEIVED A COPY OF AWESOMFIT BRAS… HIPAA PRIVACY NOTICE | | | | | | | | Initials |
| I WILL BE FINANCIALLY RESPONSIBLE FOR ALL PURCHASES, CO-PAYS AND UPGRADES THAT ARE NOT COVERED BY MY INSURANCE. | | | | | | | | Initials |
|  |
| I HAVE RECEIVED PRODUCT WARRANTY, CARE AND STORAGE (if applicable) | | | | | | | | Initials |
| I HAVE RECEIVED A COPY OF MEDICARE PROTOCOL/RESOLVING COMPLAINT FORM (if applicable) | | | | | | | | Initials |
| **UPON REQUEST**, I CAN OBTAIN A COPY OF THE MEDICARE SUPPLIER STANDARDS (if applicable) | | | | | | | | Initials |
| 48 HRS RETURN POLICY ON BRAS & PROSTHESIS | | | | | | | | Initials |
| I UNDERSTAND THAT AWESOMFIT BRAS… IS A SPECIALTY RETAIL BOUTIQUE / STORE. INFORMATION GIVEN IS TO SUPPORT MAKING LINGE­RIE DECISIONS AND IS IN NO WAY INTENDED TO REPLACE MEDICAL ADVICE FROM MY PERSONAL HEALTHCARE PROVIDERS. AWESOMFIT BRAS… MAKES NO CLAIM OR WARRANTY, OTHER THAN MANUFACTURER’S GUARANTEE OF WORKMANSHIP.  AWESOMFIT BRAS… WILL BILL MY PRIMARY INSURANCE CARRIER AS A COURTESY. I WILL BE RESPONSIBLE FOR CO -INSURANCE, CO - PAY­MENTS, UPGRADES AND DEDUCTIBLES. I MAY EVEN BE RESPONSIBLE FOR THE ENTIRE PURCHASE IF MY CARRIER DENIES THE CLAIM OR MY COVERAGE IS IN QUESTION. I UNDERSTAND THAT ANY AND ALL BALANCES OWING TO AWESOMFIT BRAS… AFTER PAYMENT BY MY PRIMARY INSURANCE CARRIER, IS DUE THIRTY (30) DAYS AFTER BILLING DATE AND AGREE TO PAY A SERVICE CHARGE OF 1-1/2 % ON AC­COUNT BALANCES FOR MORE THAN THE ABOVE - MENTIONED THIRTY (30). IF THE DELINQUENT ACCOUNT IS PLACED IN THE HANDS OF A COLLECTION AGENCY, I FURTHER AGREE TO PAY THE COLLECTION AGENCY FEE NOT EXCEEDING THIRTY PERCENT (30%).  I REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO INTIMATE IMAGE FOR SERVICES RENDERED BY THIS PRO­VIDER. I AUTHORIZE ANY MEDICAL INFORMATION CONCERNING ME TO BE RELEASED TO AWESOMFIT BRAS…, OR TO THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.  DATE: SIGNATURE OF BENEFICIARY /PATIENT: | | | | | | | | |
| 04/09/2019 | | | | | | | | |