MATERNITY KIT APPLICATION

(*Please print clearly*)

Name: ____ **DOB**: ______________

Address: ____ **Apt.**: ________

City: _______________________________ **State**: ______ **Zip**: _____________

Cell Phone: _______________________ **Email**: _________________________________

Due Date (*if applicable*): ____________

Insurance Company: ____________________________________

Insurance ID No.: __________________________________ **Group No.**: ______________

Name of your Doctor or Hospital: ____

Phone of Doctor / Hospital (*if known*): _________________________

Option 1 (*with breast pump*): ________ **HCPC** **Option 2 (*no breast pump*):** ________

: L0650 / L2620 / A6549 / E0676 / E0603 **Dx Code**: Z34.90

By signing below I acknowledge that I have read and received a copy of: <u>DME Supplier Standard Patient Rights & Responsibilities</u>.

Patient Acknowledgment & Authorization to Assignment of Benefits (PA/AOB):
I request that payment of authorized insurance be made on my behalf to and its Assigns (listed below) for products & services that they provide to me. I further authorize a copy of this agreement to be used in place of the original to release to payers any information needed to determine these benefits or compliance with current healthcare standards. I understand that I am financially responsible for my health insurance deductible, coinsurance, co-payments or non-covered services. I acknowledge receiving instruction, have demonstrated or verbalized my understanding in the proper use and care of the equipment or supplies described and will follow them. I acknowledge receipt & understand the company patient information privacy notice and that all information on this document is correct.

Patient Signature: ____ Date: _____________