REFERRING PROVIDER



ACCOUNT EXECUTIVE

PATIENT INTAKE FORM AND ASSIGNMENT OF BENEFITS

PATIENT DEMOGRAPHIC	CS	Date of Birth	INSURANCE INFO	☐ Group ☐ P.I.	☐ Work Comp	
Patient Name			Primary Insurance Co	Insurance Phon	Insurance Phone No	
Patient Address			Policy/Claim No	Group No		
City	ST Zip		Claims Mailing Address			
Phone Number	Email Address		City	ST Zip		
Social Security No	Circle one M	ale Female	Attorney Name	Phone: Fax:		
Employer Name	Employer Phone	<u> </u>	Attorney Mailing Address		Date of Injury	
send, directly to me, monies meant f to West Coast Medical, Inc. within fix service(s) which is not forwarded for I authorize West Coast Medical, Inc., directly by West Coast Medical, Inc., is my responsibility to notify West Coast Medical, Inc., is my responsibility to notify West Coast Medical, Inc., is my responsibility to notify West Coast Medical, Inc., is my responsibility to notify West Coast Medical, Inc., is my responsibility to notify West Coast I hereby authorize and direct you, my rendered. I hereby, further, give a lie you, my attorney or me. I do hereby I authorize the release of medical relinc. to appeal any denials of payment. By my signature below, I acknowled equipment. Patient Signature:	ve (5) business days. I this payment by the instead of the provide supplies need and I agree to receive past Medical, Inc. I under y attorney and/or insuration on my case to West (appoint West Coast Medicals & information need to on my behalf with my dige that I have read, under the payment of the payment	am aware that West Cosured. eded based on my presentese shipments as preferstand that, due to head ance carrier, to pay direct Coast Medical, Inc. againedical, Inc.to accept on reseded to determine and insurance carrier. I perference to the surance carrier. I perference the surance carrier.	cription from my physician. I under escribed by my doctor. Should I wis lith regulations, supplies are non-recitly to West Coast Medical, Inc., suinst any and all proceeds of any semy behalf all checks, drafts, or bills for substantiate medical necessity, mit a copy of this authorization to be	restand that I will be receiving Estand that I will be receiving Est to terminate my prescription eturnable. Ich sums that may be due for the ettlement, judgement or verdicts of exchange. I also give authorization for vote used in place of the original & also acknowledge the received.	ement made for their DME delivered to me , I understand that it the medical services that may be paid to Vest Coast Medical,	
r diloni Oignaturo.		***IF PATIENT	IS A MINOR***	·		
Guardian Signature:		Printed Name	э:	Relationship:		
		OFFICE U	JSE ONLY			