**Proof of Delivery for breast pump**

Patients Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PT SSN:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ PT Benefits#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_

Sponsors Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sponsors SSN:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_ Babies EDD #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PT Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Walk-In  Online  Faxed

How Did You Hear About us?  Online Search  Facebook Doctors Office  Friend/Family Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| QTY | Description | Serial #/Model/Size | HCPCS CODE (s) |
| 1 | Double Electric Breast Pump |  | E0603 |
|  |  |  |  |
|  |  |  |  |

**Tracking Number if Shipped:**

**Each pump comes with a unique warranty specific to that manufacturer. Please refer to your manual for this information.** It will be the patient’s responsibility to contact the manufacturer of their pump to trouble shoot any issues or get a replacement pump. In addition, an owner’s manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

By accepting this equipment, I authorize **TENS UNLIMITED INC**. to bill my insurance as a courtesy to me. If my insurance denies or does not pay my claim, I agree to contact my insurance to help get it paid. Any remaining balance will become my responsibility to pay within 14 days. A notification letter will be sent prior being sent to collection and my balance will increase which includes 18% interest along with 40% Attorney and collections fees.

Please note: Your Prescription on file will only be valid for a year from the date on your prescription. If you would like to continue to receive supplies from **TENS UNLIMITED INC**. You Must provide a new prescription.

**I have read and agree to abide by this billing policy. I authorize T.E.N.S. Unlimited INC. to bill my insurance company and to obtain any medical records on my behalf. This form and my signature are proof** that I have received all the equipment ordered by my physician.

**Please initial:**

**\_\_\_\_\_\_** Tricare is my only insurance, if other insurance is found after billing, I will agree pay my bill in full and TENS Unlimited

will not bill my other insurance.

\_\_\_\_\_\_ I have received instructions on the above equipment and understand my warranty.

\_\_\_\_\_\_ I am aware it is my responsibility to inform **TENS UNLIMITED INC.** of any address changes or change in Benefits.

­­­­­­­­­­­­­­\_\_\_\_\_ I was given a copy of **HIPPA** compliance form and **HIPPA** contact information form.

\_\_\_\_\_ I authorize TENS Unlimited Inc to Ship me 90 Breast Pump Storage bags Each month for three months.



Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_