JAG ORTHOTICS & PROSTHETICS

84-08 37th Avenue
Jackson Heights, NY 11372
Tel: (718) 665-3706
Fax:(718) 865-5129

DELIVERY RECEIPT

Patient Information

Patient Name:			Acct:			D.O.B.:	
Address:						Gender:	
City:		State:	NY	ZIP:		Telephone:	
Alternate Contact:						Alt. Tel:	

Benefits Information

Medicare:				Insurance:	
Medicaid ID:		SQ #:		Number:	

DR NAME:			
Address:			
Telephone:		NPI:	

SERIAL/LOT #:	HCPCS:	DESCRIPTION	COST	QTY
		****NO Copay is Due by Patient****		

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Jag Orthotics & Prosthetics for medical supplies furnished to me by Jag Orthotics & Prosthetics.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurer's and their agents and assigns.
4. Jag Orthotics & Prosthetics to obtain medical or other information necessary in order to process my claim(s), incldiuing determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.
5. Jag Orthotics & Prosthetics to contact me by telephone or mail regarding my medical supplies order.

I request that payment to Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Jag Orthotics & Prosthetics or its afiliates, for any medical supplies and/or medications furnished to me by Jag Orthotics & Prosthetics. I authorize any holder of medical information aboout me to release to Jag Orthotics & Prosthetics or its afiliates, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligiblity informaiton and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible. I accept delivery of the above equipment.

Signature: _____ **Date of Delivery:** _____