

Insurance Department Fax Cover Sheet



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To: Insurance Department	From: Paul Karp
Fax: 1-800-548-3367	Rep Name: Paul Karp
Phone: 1-800-548-3370	Rep Insurance #:
Pages:	E-mail:
Date:	OfficeCare Clinic #:
New Patient <input type="checkbox"/>	Existing Patient <input type="checkbox"/>
Preferred method of shipping:	Patient <input type="checkbox"/> Other <input type="checkbox"/>
Preferred method of communication:	Phone <input type="checkbox"/> E-mail <input type="checkbox"/>

DJO Insurance Bracing Program Checklist

Please follow the steps listed below for the DJ Orthopedics Bracing Program. Completion of these steps will ensure the patient receives the product as soon as possible. Please remember when information is missing it will take additional time to process the claim.

Patient Name: _____
(Always Include)

Date: _____

Product Description: _____

Product #: _____

Please check off the items included in THIS fax only. Please keep the checklist attached to the patient's claim if needed for future reference. (Send a new cover sheet for every subsequent transmittal.)

Faxed by Sales Rep (Check Box)

Received **Missing**

<input type="checkbox"/>	Patient INSURANCE BILLING and RX Form (always include diagnosis)
<input type="checkbox"/>	All Signatures - Insurance Billing Form, Rx (If Separate), ABN (If Required)
<input type="checkbox"/>	Copy of prescription
<input type="checkbox"/>	Copy of patient's insurance information card
<input type="checkbox"/>	Custom Brace measurements and /or product with correct size and color
<input type="checkbox"/>	Patient Notes/Chart Notes/OP Report/X-Rays/P.T. Notes
<input type="checkbox"/>	LMN (Letter of Medical Necessity)
<input type="checkbox"/>	Other:
<input type="checkbox"/>	PRODUCT REBILL INFO, ORIGINAL ORDER #:

Notes:

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