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 ☐	**Existing Patient** ☐
Preferred method of shipping:	Patient ☐ Other ☐
Preferred method of communication:	Phone ☐ E-mail ☐

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** ☐

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

Notes: