INSURANCE BILLING AND RX INFORMATION

ORDER #	
ORDER AMOUNT	
PREAUTHORIZATION #	

Rep Name _____
Rep Acct # _____
Phone # _____
Ship to: _____

MARK ONE: ☐ Custom ☐ Patient Ready

MARK ONE: ☐ Post-op ☐ Shoulder ☐ ACL
☐ Cold Therapy ☐ OA ☐ Walker Boot
☐ Other _____

Doctor Name _____
Doctor Phone _____
Doctor UPIN # _____
Date of Injury ____/____/____ **Required** for WC/ AUTO INJURY
Date of Surgery ____/____/____
Patient Diagnosis ICD-9 Code # _____

LIMB: RIGHT _____ LEFT _____ N/A _____
Required by Medicare

Product Description _____
Doctor's Signature: _____

PATIENT INFORMATION (MUST BE FILLED OUT)

Name _____
Address _____ Apt.# _____
City _____ State _____ Zip _____
Phone (Home) _____ (Work) _____
Social Security Number _____
Date of Birth _____ Sex ☐ M ☐ F
Relationship to Insured _____ ☐ Self ☐ Spouse ☐ Child

INSURANCE INFORMATION (ATTACH OR FILL OUT)

Insured's Name: _____
Insurance Co. Name: _____
Address _____
City _____ State _____ Zip _____
Phone _____ Subscriber _____
Policy # _____ Group # _____
Employer W/C ☐ Claim # _____
Auto ☐ Claim # _____

FOR WC CLAIMS ONLY

Employer Name:		
Employer Address:		
City:	ST:	Zip:
Employer Phone: ( )		

SECONDARY INSURANCE INFORMATION (ATTACH OR FILL OUT)

Insured's Name: _____
Insurance Co. Name: _____
Address _____
City _____ State _____ Zip _____
Phone _____ Subscriber _____
Policy # _____ Group # _____

CO-PAY INFO

☐ Visa ☐ Mastercard

Cardholder _____ Amount _____
Card Number _____ Expiration Date _____

I permit a copy of this authorization to be as valid as the original. I agree to use all products only in the manner for which they were intended and not to attempt to make any modifications or changes of any kind or description in the product. These products are prescription only. These products are to be utilized only as directed by my physician. I agree that dj Orthopedics, LLC, is not responsible for defects in, or damages caused by, non-dj Orthopedics, LLC, products.

CONSENT FOR TREATMENT, PROOF OF DELIVERY, AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, DJ ORTHOPEDICS, LLC OR ITS BUSINESS PARTNERS

I acknowledge and I authorize dj Orthopedics, LLC, or its Business Partners to deliver, teach, administer, or perform, as necessary, the product and treatment prescribed by my physician, and that I have received the product and such services. I authorize dj Orthopedics, LLC, or its Business Partners, to submit a claim for such product to my insurer on my behalf, and I assign the benefits payable by my insurer for such product to dj Orthopedics, LLC or its Business Partners. I authorize my physician and dj Orthopedics, LLC, or its Business Partners, to release any of my medical information required for my insurer to process the claim. I understand that I am responsible for, and I agree to pay, any portion of the amount due for such product not paid by my insurer, whether resulting from deductibles, co-pays, or otherwise. I acknowledge that I have reviewed and understand my Patient Rights and Responsibilities on the reverse side of this form.

Signature _____ Date Signed _____

PRODUCT DELIVERY ACKNOWLEDGEMENT (REQUIRED FOR MEDICARE CLAIMS) I acknowledge receipt of the product referenced above on this date and that I have not received the same or similar service within the last five (5) years.

Signature _____ Date Product Received _____

ORIGINAL

JOB#45891, FORM#DJO-INS-03, CUSTOMER:DJ ORTHOPEDICS, FILE NAME:A45891, DATE:2-17-03, INIT.:JEF

INSURANCE BILLING AND RX INFORMATION

ORDER #	
ORDER AMOUNT	
PREAUTHORIZATION #	

Rep Name _____
Rep Acct # _____
Phone # _____
Ship to: _____

MARK ONE: ☐ Custom ☐ Patient Ready

MARK ONE: ☐ Post-op ☐ Shoulder ☐ ACL
☐ Cold Therapy ☐ OA ☐ Walker Boot
☐ Other _____

Doctor Name _____
Doctor Phone _____
Doctor UPIN # _____
Date of Injury ____/____/____ **Required** for WC/ AUTO INJURY
Date of Surgery ____/____/____
Patient Diagnosis ICD-9 Code # _____

LIMB: RIGHT _____ LEFT _____ N/A _____
Required by Medicare

Product Description _____
Doctor's Signature: _____

PATIENT INFORMATION (MUST BE FILLED OUT)

Name _____
Address _____ Apt.# _____
City _____ State _____ Zip _____
Phone (Home) _____ (Work) _____
Social Security Number _____
Date of Birth _____ Sex ☐ M ☐ F
Relationship to Insured _____ ☐ Self ☐ Spouse ☐ Child

FOR WC CLAIMS ONLY

Employer Name:		
Employer Address:		
City:	ST:	Zip:
Employer Phone: ( )		

INSURANCE INFORMATION (ATTACH OR FILL OUT)

Insured's Name: _____
Insurance Co. Name: _____
Address _____
City _____ State _____ Zip _____
Phone _____ Subscriber _____
Policy # _____ Group # _____
Employer W/C ☐ Claim # _____
Auto ☐ Claim # _____

SECONDARY INSURANCE INFORMATION (ATTACH OR FILL OUT)

Insured's Name: _____
Insurance Co. Name: _____
Address _____
City _____ State _____ Zip _____
Phone _____ Subscriber _____
Policy # _____ Group # _____

CO-PAY INFO

☐ Visa ☐ Mastercard

Cardholder _____ Amount _____
Card Number _____ Expiration Date _____

I permit a copy of this authorization to be as valid as the original. I agree to use all products only in the manner for which they were intended and not to attempt to make any modifications or changes of any kind or description in the product. These products are prescription only. These products are to be utilized only as directed by my physician. I agree that dj Orthopedics, LLC, is not responsible for defects in, or damages caused by, non-dj Orthopedics, LLC, products.

CONSENT FOR TREATMENT, PROOF OF DELIVERY, AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER, DJ ORTHOPEDICS, LLC OR ITS BUSINESS PARTNERS

I acknowledge and I authorize dj Orthopedics, LLC, or its Business Partners to deliver, teach, administer, or perform, as necessary, the product and treatment prescribed by my physician, and that I have received the product and such services. I authorize dj Orthopedics, LLC, or its Business Partners, to submit a claim for such product to my insurer on my behalf, and I assign the benefits payable by my insurer for such product to dj Orthopedics, LLC or its Business Partners. I authorize my physician and dj Orthopedics, LLC, or its Business Partners, to release any of my medical information required for my insurer to process the claim. I understand that I am responsible for, and I agree to pay, any portion of the amount due for such product not paid by my insurer, whether resulting from deductibles, co-pays, or otherwise. I acknowledge that I have reviewed and understand my Patient Rights and Responsibilities on the reverse side of this form.

_____ _____
Signature Date Signed

PRODUCT DELIVERY ACKNOWLEDGEMENT (REQUIRED FOR MEDICARE CLAIMS) I acknowledge receipt of the product referenced above on this date and that I have not received the same or similar service within the last five (5) years.

_____ _____
Signature Date Product Received

PATIENT

JOB#45891, FORM#DJO-INS-03, CUSTOMER:DJ ORTHOPEDICS, FILE NAME:A45891, DATE:2-17-03, INIT.:JEF

SUPPLIER STANDARDS

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit HCFA, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits supplier from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number, i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish HCFA any information required by the Medicare statute and implementing regulations.

PATIENTS RIGHTS AND RESPONSIBILITIES

It is understood by the parties to this agreement that the word "COMPANY" when used in this agreement, refers to dj Orthopedics, LLC. The PATIENT is understood to be the person receiving supplies from the Company. Individuals signing for the PATIENT, represent that they are duly authorized and that once signed, this agreement becomes binding upon the patient.

The PATIENT agrees that if they or their respective insurance company(s) fail to make PAYMENT on any purchase within ninety (90) days, after it becomes due, the PATIENT will be held responsible for those debts.

PATIENT'S wishing to express their dissatisfaction, concern or content with any COMPANY Service should contact the COMPANY, on business days between 8am and 5pm. Your comments will be fully reviewed and acted upon, as necessary. Your comments may be given without fear of reprisal by the COMPANY, or any of it's employees.

The PATIENT retains the right to refuse COMPANY product and assumes full responsibility for any consequence whatsoever relating to REFUSAL of any product delivered to the patient by a healthcare professional. The COMPANY retains the RIGHT TO REFUSE DELIVERY of product to any patient, at any time. This policy is in the interest of health and safety of COMPANY employees.

It is understood that all PATIENT'S personal information shall be kept strictly confidential by the COMPANY.

MESSAGE FROM DJ ORTHOPEDICS

Thank you for purchasing your product from the OfficeCare Program of dj Orthopedics, LLC.

dj Orthopedics is a leading manufacturer of orthopedic support products for the prevention and treatment of injuries.

For more information on our products and services, please visit us at our Web site at www.djortho.com