

Patient Worksheet

Please complete the information below in order for USA Mobility to verify your insurance and determine reimbursement eligibility. Your privacy is important to us and any information provided in this worksheet will remain confidential. We are HIPPA compliant and you can review a copy of our privacy policy at www.usamobility.com.

A. Personal Information:

Patient's Name: _____	Height: _____	Gender: _____
Patient's Phone: (____) _____	Weight: _____	Right / Left Handed _____
Physical Address: _____ _____	Do you live in a nursing home? Y N	
_____	Are you on hospice? Y N	
	Do you live in a (please circle) house, mobile, apartment, other	

B. Medical History:

Upper Extremities: _____

Lower Extremities: _____

C. Insurance Information:

Primary Insurance: _____	Secondary Insurance: _____ (if applicable)
Health Insurance Claim Number: _____	Policy Number: _____
Effective Date of Part B: ____ / ____ / ____	Plan / Group: _____
Deductible Amount unpaid \$ _____	Phone # (____) _____

D. Doctor's Information:

Name of Doctor Prescribing this product: _____	Speciality: _____
How long have you been seeing this doctor? _____	Last Appointment: ____ / ____ / ____
Clinic's Name: _____	Telephone Number: (____) _____
Clinic's Address: _____ _____	Fax Number: (____) _____

E. For Office Use Only:

VER: ____ / ____ / ____ UPIN: _____ 2nd BA _____

Comments: _____

Mail or Fax back to USA Mobility at 409 N. Tejon St STE 202 Colorado Springs, CO 80903 or Fax (719)630-0291