Progressive Prosthetic & Orthopedic Services
380 Cleveland Place
Va. Beach, VA 23462

Statement to Permit Payment of Medicare/Insurance Carrier(s)
Benefits to Provider, Physicians and Patient

Name of Beneficiary/Patient

Health Insurance ID Number/HICN

"I request that payment of my authorized Insurance Carriers/Medicare benefits be made either to me or on my behalf to Progressive Prosthetic & Orthopedic Services, Inc. for any services furnished me by Progressive Prosthetic & Orthopedic Services, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or to my Insurance Carrier and its agents, any information needed to determine these benefits or the benefits payable for related services. I authorize Progressive Prosthetic & Orthopedic Services, Inc. to contact me by telephone concerning the furnishing of a Medicare-covered item."

Signature of Patient/Representative

Date

Patient Name "by" Representative/Parent Name
If patient unable to sign

Address of Representative/Parent

Reason patient unable to sign

Relationship to Patient

I understand and take financial responsibility, at the time of delivery, for therapeutic healing shoes & foot orthotics to include all arch supports and shoe build ups. I understand Medicare's medical policy does not typically cover such items, nor do most private insurance carriers. However, I can request an insurance claim submission, if desired.

Signature of Patient/Parent

Date

Revised 5/09
Forms/Signature