TRANSCEND MEDICAL

Going Beyond The Limits

800-403-3740

Delivery Date: ______________

Pick-Up Date: _______________

Reason for Pick-Up: __________

Last Name________________________ First Name__________________ MI __________ DOB ___________

Height _______ Weight ________ Sex: M or F Phone ___________________ Cell Phone _____________________

Street Address _________________________ City _______________ St _____ Zip __________ DX__________________

Email address: ________________________________ Other Contact ____

Name on Primary Insurance ________________________________ Insurance Phone # _________________________

Subscriber's Name _______________________________________ DOB _________ Phone ____________________

ID # ____________________________ Group # _____________ Relation: Self___ Spouse ____ Child ____

Name of Secondary Insurance _______________________________ Insurance Phone # ________________________

Subscriber's Name _______________________________________ DOB _________ Phone ____________________

ID # ____________________________ Group # _____________ Relation: Self___ Spouse ____ Child ____

QTY	HCPS CODE	Product Description	Serial #	Manufacturer	P or R	Amount Paid

Appropriate for Home: Yes ___ NO ___ Understands operation of equipment _____ Has Caregiver and instructed _______

ASSIGNMENT OF BENEFITS (AOB)

I request that payment of authorized Medicare benefits be made to me or on my behalf to Transcend Medical for durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and its agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the CMS-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

Supplier Standards

The products and/or services provided to you by Lobo Home Health dba, Transcend Medical are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.

By signing I agree I received in the new Patient packet that will include the following

* **Hours of Operation**
* **Rights and Responsibilities**
* **Complaint Procedure/Emergency Preparedness**
* **Home Safety Information**
* **Patient Privacy Information**
* **Equipment Warranty Information/Assignment of Benefits/Correct Information**
* **Equipment/ Supplies Provided**

RETURNING PRODUCT AGAINST MEDICAL ADVISE

I have been instructed and understand the Acknowledgment and Waiver, against Medical Advice.

BY Signing below, you agree to AOB statement, and you have received Welcome packet and informed of our resource page on our website www.transcendmedical.net.

I HAVE READ AND UNDERSTAND THE PROVISIONS OF THIS FORM. I UNDERSTAND THAT MY SIGNATURE BELOW SHALL BE EVIDENCE OF MY AGREEMENT TO THE PROVISIONS OF THIS FORM. I HAVE READ AND UNDERSTAND THE COMPANY'S RETURN POLICY.

_________________________________ ________ _________________________________

CUSTOMER SIGNATURE DATE TRANSCEND MEDICAL REPRESENTATIVE

_________________________________ _________________________________

BY, IF OTHER THAN CUSTOMER PRINTED NAME & RELATIONSHIP TO PATIENT