

BENEFIT REQUEST FORM

PATIENT'S NAME (First, Middle Initial, Last)		Address (if different from insured)	
Home Phone		Business Phone	
Date of Birth	Soc. Sec No.	Sex Male Female	Pat's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Is your Spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" give spouse's first name and <u>date of birth</u> .	If claim is on child, is that child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Spouse or child is employed, give name, address and telephone number of employer.			
Is patient also covered for benefits by: Any other Group Health Insurance of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No Group prepayment arrangement providing medical care or treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Coverage provided by college, employer, Union Welfare Plan, any federal, state, provincial, or other government agency? <input type="checkbox"/> Yes <input type="checkbox"/> No No Fault Automobile Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" describe, give plan name and number, and address of office to which claims are submitted, if known.			
Insured's Name (If other than patients)		Address	Telephone #
First	Middle	Last	
Insured's Soc. Sec. No.		Employer's Name	Address
			Telephone #
Primary Insurance Coverage Name		Agent's Telephone # Address	Policy #
Additional Insurance Coverage	Policy Group No.	Effective Date	Address
Telephone #			
<input type="checkbox"/> Medicare _____			
<input type="checkbox"/> Medicaid _____			
<input type="checkbox"/> Other _____			
I HEREBY ACKNOWLEDGE RECEIPT OF ONE OR MORE OF THE AMERICAN, INC. TRADITION OFF-THE-SHELF, TRADITION CUSTOM, WOMEN'S TRADITION OFF-THE-SHELF, WOMEN'S TRADITION CUSTOM, COUNTERFORCE OA OFF-THE-SHELF, WOMEN'S COUNTERFORCE OA OFF-THE-SHELF, COUNTERFORCE OA CUSTOM, WOMEN'S COUNTERFORCE OA CUSTOM, POST-OP KNEE BRACE, POST-OP ELBOW, FUNCTIONAL ELBOW BRACE, TRADITION X2K, TRADITION CUSTOM X2K, COUNTERFORCE X2K BRACE OR CONTINUOUS PASSIVE MOTION MACHINE. AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment of my insurance benefits directly to: MedSource of St. Louis, Inc. I UNDERSTAND AND I AM FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY THE INSURANCE CO. In the event any amount is not paid when due, you shall pay MedSource of St. Louis, Inc. ("MedSource") interest on said amount at the rate of 1.5% per month. In the event any amount due hereunder is not paid when due and shall pay MedSource its attorney's fees, expenses and court costs in addition to the full amount due hereunder. I also accept responsibility for any damage to any rental products (CPM). I authorize release of all information acquired in the course of my examination or treatment to my Insurance Company, or to Agents in my behalf. I know that I have a right to receive a copy of this authorization upon request and agreement that a photographic copy of this authorization is a valid as the original.			
SIGNED: <input checked="" type="checkbox"/> _____		DATE: _____	
Patient or Parent if Minor			