

DME

Patient _____

Date of Birth _____

DME CERTIFICATION COVERAGE

Reference # _____

Date _____

Date Called _____

Contact Name _____

Insurance _____

Coverage Amount _____

Deductible \$ _____

Met \$ _____ Not Met \$ _____

Covered Item Yes ____ No ____

Authorization Needed Yes ____ No ____

Lymphedema Garments

☐ **ReadyWrap Calf: A6583**

☐ ____ Left

☐ ____ Right

☐ **Tribute Wrap Below Knee: A6524**

☐ ____ Left

☐ ____ Right

☐ **ReadyWrap Foot: A6587**

☐ ____ Left

☐ ____ Right

☐ **Extender Strap: A6593**

☐ ____ Left

☐ ____ Right

☐ **Ready Wrap Calf Custom: A6517**

☐ ____ Left

☐ ____ Right

☐ **Tribute Wrap Below Knee Custom: A6525**

☐ ____ Left

☐ ____ Right

☐ **ReadyWrap Foot Custom: A6516**

☐ ____ Left

☐ ____ Right

Durable Medical Equipment (DME) & Financial Policy Statement

I understand that my physician's staff performs a courtesy inquiry with my insurance carrier to help determine if Durable Medical Equipment is a covered benefit. However, this inquiry is not a guarantee of payment or coverage.

I acknowledge that:

- My physician's office is not responsible for insurance misquotes or claim denials.
- It is my sole responsibility to understand my insurance policy, including deductibles, co-insurance, and exclusions.
- I agree to be financially responsible for the full cost of all services and equipment provided to me or my dependents, regardless of the insurance outcome.

Custom Equipment Notice: I understand that certain Durable Medical Equipment (such as orthotics) is custom-manufactured specifically for my anatomy. Once the order is placed, these items cannot be returned, exchanged, or refunded for any reason.

Signature of patient or parent of minor

Date

Signature of witness

Date