

OFFICE NAME: _____

Proof of Delivery & Financial Responsibility Form

Patient Name: _____ Date of Birth: _____

Insurance ID: _____ Date of Service: _____

1. Itemized Description of Garments

Item Name / Code (HCPCS)	Description (Compression Level / Style)	Quantity	Fit Verified (Y/N)

2. Patient Acknowledgment of Receipt

I certify that I have received the custom or off-the-shelf lymphedema compression garments listed above. I confirm that:

- The garments have been fitted to my satisfaction.
- I have received instructions on the proper use, care, and laundering of these items.
- I have been informed of the manufacturer's warranty (if applicable).

Patient/Guardian Signature: _____ Date: _____

Office address / phone: _____

OFFICE NAME: _____

3. Financial Responsibility Waiver

Important: Please Read Carefully

Our office will submit a claim to your insurance carrier for the items listed above. However, insurance coverage for lymphedema garments varies significantly by plan and medical necessity guidelines.

By signing below, I agree to the following:

Authorization: I authorize the release of any medical information necessary to process this claim and authorize payment of medical benefits directly to the provider. I understand that while the office may obtain a prior authorization from my insurance carrier, this authorization is a determination of medical necessity only and does not guarantee payment. Final payment is determined by the insurance carrier at the time the claim is processed based on my eligibility and plan benefits.

Financial Responsibility for Non-Covered Services: In the event that my insurance carrier determines that these garments are "non-covered," "not medically necessary," or "investigational"—or if the carrier reverses a prior authorization upon final claim review—I assume full financial responsibility for the total cost of the items. I understand that my insurance plan is a contract between myself and the carrier, and I am ultimately responsible for any balance they do not pay.

Balance Responsibility: I am responsible for any deductibles, co-insurance, or remaining balances not paid by my insurance provider.

No Returns: I understand that due to the personal nature of compression garments and hygiene regulations, these items cannot be returned once they have been delivered and fitted.

Patient/Guardian Signature: _____ Date: _____

4. Staff Verification (Internal Use Only)

I verify that the above items were delivered and fitted to the patient, and that the patient demonstrated an understanding of garment application.

Staff Signature: _____ Date: _____