A D MEDICAL, INC.
America's Dietitians
Phone: 888-785-7370 • Fax: 888-785-7380
www.americasdietitians.com

MEDICAL EQUIPMENT ASSIGNMENT OF BENEFITS

DIETITIAN / PCC: _____

Patient Name: _____ Referral Source_____

Patient Address: _____

_____
(City) (State) (Zip)

Patient Phone: _____ Secondary Phone: _____

Caregiver Name and Phone: _____

Date of Birth:_____/_____/_____ WT:_____lbs. HT_____in SEX: M F

Primary Insurance:_____ Policy No.:_____

Secondary Insurance:_____ Policy No.:_____

Physician Name_____ NPI:_____

Address: _____
(City) (State) (Zip)

Phone:_____ Fax: _____

I acknowledge I have been evaluated for proper size and style of below indicated medical equipment by a qualified member of AD Medical Supply, Inc. By my signature below, I certify that the items described below have been selected in person and permission is granted to pursue approval from the physician treating my diabetes.

	MEASUREMENT / SIZE	ITEM	HCPCS
BACK BRACE:	_____ / _____	Lumbar Orthosis	☐ **(L0648)**
		Lumbar-Sacral Orthosis	☐ **(L0650)**
KNEE BRACE:	_____ / _____	Osteoarthritis Knee Orthosis	☐ **(K0901)**
__L __R __BOTH		Post-Op Knee Orthosis	☐ **(L1833)**
ANKLE BRACE:	_____ / _____	Sports Ankle Lacer	☐ **(L1902)**
__L __R __BOTH		Ankle-Foot Orthosis	☐ **(L1930)**
		Ankle Stirrup Brace	☐ **(L4350)**
WRIST BRACE:	_____ / _____	Wrist / Hand & Finger	☐ **(L3809)**
__L __R __BOTH			

Patient or Authorized Signature _____ Date_____

Reason patient is unable to sign: _____Relationship_____

Fitter Signature: _____ PCC: _____