ONE SOURCE MEDICAL SOLUTIONS, INC.

One Company. Multiple Solutions.™

Medical Equipment/Supplies, Incontinence/Urological and Ostomy Referral

Last Name: _____ First Name: _____ MI: _____

HIC#: _____-_____-_____ SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____-_____

Sex (circle one): M F Height (inches): _____ Weight: _____

Responsible Party Information

Primary Responsible Party (circle one): Medicare Medicaid Other (if other, complete the following):

Insurance Company Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Plan Name: _____ Policy/Group#: _____

Phone: _____ Contact Person: _____

Referring Physician Information

Name: _____ NPI: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Diagnosis: _____

ICD-9 Codes: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Additional Comments/Instructions: _____

_____

_____

Signature: _____ Date: _____

Send completed form along with your signed order(s) to:
ONE SOURCE MEDICAL SOLUTIONS, INC.
FAX: (214) 421-7001

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DALLAS, TEXAS 75235
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