ONE SOURCE MEDICAL SOLUTIONS, INC.

One Company. Multiple Solutions.™

Medical Equipment/Supplies, Therapeutic Supports and Ergonomic 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): VR/DARS Medicare Medicaid Other Payor/Funding Source:

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-10 Codes: 1. __________ 2. __________ 3. __________ 4. __________ 5. __________

Additional Comments/Instructions: ____

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____

Signature: ____________________________________ Date: _______________________

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

1555 W. MOCKINGBIRD LANE, SUITE 210
DALLAS, TEXAS 75235
TOLL FREE (877) 4RX-SHOES
PHONE (214) 421-7000 FAX (214) 421-7001