



2600 Philmont Avenue
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FAX COVER SHEET

NEW PATIENT REFERRAL/REQUEST FOR INSURANCE BENEFITS

Date: _____ Number of pages: ___(including cover sheet)

To:	Comfort and Care Medical	From:	(First name, Last name, Title)
Attn:	Patient Referrals Dept.	Clinic:	
Phone#:	215-244-9130	Phone#:	(xxx-xxx-xxxx)
Fax#:	215-244-9133	Fax#:	(xxx-xxx-xxxx)

PATIENT NAME: _____

CHECKLIST:

Patient Face Sheet from your clinic **OR** Comfort and Care Medical Patient Data Form
 Privacy Practice Form (HIPAA)
 Financial Policy Form
 Measurement Form(s) for product(s) ordered

AFFECTED BODY PART(S): arm/hand leg/foot breast head/neck other _____

ANTICIPATED PRODUCT(S):

- DAYTIME, ELASTIC SUPPORT** Jobst, Lymphedivas, Medi, Sigvaris, Juzo, Bioflect
- DAYTIME, IN-ELASTIC SUPPORT** CircAid, Juzo, Farrow, Ready Wrap
- NIGHTTIME, IN-ELASTIC SUPPORT** Relax, Tribute, CircAid, JoViPak, Mobiderm
- COMPRESSION TOPS** Bellisse, Prairie Wear, WearEase, Bioflect
- REDUCTION KITS** CircAid, Farrow

PROVIDER SIGNATURE & NPI NUMBER:

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