2600 Philmont Avenue
Suite 109
Huntingdon Valley, PA 19006
(T) 215-244-9130 (F) 215-244-9133

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: