

UroMatrix Medical Systems

4811 Technology Drive Martinez, GA 30907 Phone: 706-863-7100 FAX: 706-863-8882

Patient Name (First, Middle Initial, Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

Date of Birth: ____/____/____

Status: Single Married Other **Employed?** YES NO

Has Medicare ever bought you a Vacuum Erection Device? _____

If Yes. When? _____

Is Medicare your primary insurance? YES NO **Medicare Policy #** _____

Other Primary Insurance Company: _____

Group# _____ Policy # or ID# _____

Phone# (_____) _____ - _____ (on back of insurance card)

CMS# _____ (i.e. H4526 OR R4526 or E4526)

Secondary Insurance Company: _____

Group# _____ Policy # or ID# _____

Phone# (_____) _____ - _____ (on back of insurance card)

Doctor's Name _____

Doctor's Number _____

ASSIGNMENT OF BENEFITS

This form gives authorization to UroMatrix Medical Systems/ Pos-T-Vac or Distributors to file my Medicare and/or private insurance benefits for the service furnished to me by the supplier for the procedure code L7900 (Vacuum Erection Device - for treatment of Erectile Dysfunction). I request payment of benefits to the party accepting assignment for reimbursement.

I authorize UroMatrix Medical Systems/Pos-T-Vac or Distributors to release information required to obtain any medical information (i.e. medical records, clinical notes, and insurance information) pertaining to this claim or any information needed to determine this benefit or the benefits payable for related services.

Authorized by:



_____ / ____ / ____

Patient Signature

Date

To expedite your order, please FAX this form to (706)863-8882.