FLEX *Orthopedic Services, L.P.*

Rep_____

Phone (713) 838-8610 Fax: (866) 743-0147

Surgery/Special Order Form

Patient Name: _____ DOB_____ M/F_____

Address:_____ City_____ Zip_____

Home:_____ Daytime Phone: _____ Email:_____

Physician_____ DX:_____ SX Date:_____ SX Time:_____

Insurance Co.: _____ Policy Holder: _____ Policy Holder's DOB: _____

Policy Number: _____ Group Number: _____

Flex Orthopedic Services, L.P. expects that your insurance company may not pay for the item(s) that are described below. Your insurance company will only pay for services it determines to be "reasonable and necessary" per your insurance company medical policies. If your insurance company determines a particular service is not "reasonable and necessary" under your insurance company program standards, your insurance company will deny payment for that service. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. As a courtesy to you, we will provide the prescribed products at a reduced rate for services denied as "not reasonably necessary or experimental".

These special order /surgery items are non-returnable if opened or used

- ☐ **Shoulder CPM** ☐ LT ☐ RT Serial # _____
- ☐ **Knee CPM** ☐ LT ☐ RT Serial # _____
- ☐ **Sling / Clinic Shoulder** _____
- ☐ **Crutches** _____
- ☐ **Walker with Wheels** _____
- ☐ **Heat/Cold/Compression Therapy** ☐ Knee ☐ Shoulder ☐ Ankle ☐ Wrist Hot/cold/compression _____
- ☐ **Delivery** _____
- ☐ **Knee Immobilizer** _____
- ☐ **Shoulder Immobilizer** _____
- ☐ **ARC Brace** _____
- ☐ **Pillow Abduction** _____
- ☐ **Pneumatic Fx Boot** _____
- ☐ **Cervical Collar** _____
- ☐ **Post-op Brace** _____
- ☐ **DVT /SCD** Serial # _____
- ☐ **OTS ACL** ☐ **OA** ☐ LT ☐ RT _____
- ☐ **DVT/SCD Garment /Sleeve** ☐ LT ☐ RT _____
- ☐ **LSO** ☐ **TLSO** _____
- ☐ **Tens Unit** _____
- ☐ **CPM Pad Kit** _____
- ☐ **Commode** _____
- ☐ **Other** _____

☐ **YES - I WILL RECEIVE THE ITEM(S) LISTED ABOVE**
I have been notified by Flex Orthopedic Services, L.P. that my insurance company may not consider these items medically necessary based on current medical policies or plan limitations. I agree to be personally and fully responsible for payment

☐ **NO - I WILL NOT RECEIVE THE ITEM(S) LISTED ABOVE**
I will not receive these items or services. I will not be held responsible for payment for these items or services.

Certificate of Medical Necessity

The above modalities are required during the normal course of patient rehabilitation in order to protect the injury and/or surgical repair. These modalities will allow the patient to resume normal activities of daily living more quickly and at less cost. These modalities are an essential part of our post-operative or post-injury treatment and are prescribed to preserve the integrity of the surgical procedure and/or prevent further damage to the site.

Physicians Signature: _____ **Date:** _____

I hereby authorize payment of medical benefits directly to Flex Orthopedic Services, L. P. for services rendered. I further authorize the release of any medical information necessary for determining the extent of third party coverage and for processing any insurance claim on my behalf. I understand that this authorization applies only in connection with services/supplies by or through Flex Orthopedic Services, L.P. or its agent and does not constitute an authorization for the release of future unrelated information. I understand the benefits related to services and/or supplies provided by Flex Orthopedic Services, L.P. or its agent will be mailed directly to Flex Orthopedic Services, L.P. I permit a copy to this authorization to be as valid as the original. I agree to use all products only in the manner for which they were intended and not to attempt to make any modifications or changes of any kind or description in the product. These products or services are prescription only. These products or services are to be utilized only as directed by my physician. I have been provided with written product instructions, all applicable warranty information as well as the required Medicare Standards and have been informed of the complaint resolution protocol. All liabilities for products are the responsibilities of the manufacturer and patient agrees to hold Flex Orthopedic Services, L.P. or its agent harmless. I understand that all costs of services and supplies not paid by my insurance carrier will become my responsibility in 90 days. Assignment of insurance benefits does not guarantee that my insurance company will provide coverage. If litigation or collections is necessary to collect unpaid debts, the undersigned agrees to pay for all costs incurred.

Patient/Insured's Signature: _____ **Date:** _____

Note: Your health information will be kept confidential. Any information that we collect about you on th is form will be kept confidential in our offices