Rehabilicare
Bringing your care home.

A Division of Compex Technologies, Inc.
P. O. Box 30244
Tampa, FL 33630-3244
(800) 343-0488
Corporate Fax: (800) 272-6458
www.rehabilicare.com

Precert Form

Please FAX this completed form, Rx form and Patient's insurance card to the fax number listed below. If no fax number is listed, fax form to Corporate fax number:

Date: _____
Clinic Contact: _____
Clinic Phone Number: _____
Call with status to: ☐ Clinic ☐ Patient ☐ Rep.
Rep. Name: _____

Unit Type To Be Shipped: _____
To: ☐ Clinic ☐ Patient
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

Patient's Social Security #: _____
Patient's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Birth Date: __ __ __ ☐Male ☐Female

Date of Injury: ___/___/___
Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____

Type of Claim:
☐ W/C ☐ Group Insurance
☐ HMO ☐ Self-Pay
☐ Medicare ☐ Auto

Patient's Relationship to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other
Insured's Name: _____
Insured's SS#: _____

Primary Insurance: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Policy #: _____ Claim #: _____
Group #: _____ Group Name: _____
Adjuster Name: _____

Prescribing Physician: _____
Physician's Clinic: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Dispensing Clinic: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Patient Signature Required For Assignment Of Benefits:

I hereby authorize payment of medical benefits to Rehabilicare, A Division of Compex Technologies, Inc. for services furnished. I further authorize the release of any medical information required to process an insurance claim on my behalf, I permit a copy of the authorization to be as valid as the original. All costs of the device and supplies not paid for by my insurance company will become my responsibility.

Print name: _____ Date: _____

Patient's Signature: _____
(Parent or Guardian Signature if under 18 yrs. old)

(electronically fabricated signature not acceptable.Patient required to sign printed copy of form OR sign tablet PC screen with form image.)

Worker's Compensation: Right to Choose

The equipment I received is the equipment ordered by my authorized physician, and was supplied by Rehabilicare, A Division of Compex Technologies, Inc.. I choose to use this particular equipment and this particular company. I choose Rehabilicare as my provider of my own volition and understand that I have this right if applicable under the worker's compensation law in the state of my residence. My insurance carrier may NOT change the equipment or company providing these services without my prior knowledge and approval. I choose to have Rehabilicare as the provider of any future supplies and accessories.

Print name: _____ Date: _____

Patient's Signature: _____

(electronically fabricated signature not acceptable.Patient required to sign printed copy of form OR sign tablet PC screen with form image.)