Please return your completed and signed form to Wellstart by email, fax, or the included prepaid envelope.

- **Email: customerservice@wellstartmedical.com**
- **Fax: 1-800-971-3199**

Wellstart MEDICAL

1. I, the undersigned below, am consenting to assign my insurance benefits to Wellstart Medical, LLC ("Wellstart" or the "Company"), and authorize Wellstart to contact my insurance company to verify my benefits, contact my physician to obtain a prescription order form, and contact me to discuss my order of durable medical supplies.
2. I understand that Wellstart has verified benefit coverage with a representative of the insurance company responsible for paying for my durable medical supplies. I also understand that verification of benefits is not a guarantee of payment and that charges may be subject to medical review and/or reasonable or customary charges as determined by my insurance company or other party responsible for paying for my durable medical supplies.
3. I certify that I have active and valid insurance coverage and have supplied Wellstart with up-to-date and correct and necessary information. Failure to provide updates to any of the information supplied to Wellstart may result in denial of payment to the Company. I understand that charges or payments which are not paid by my insurance company or other responsible party will ultimately be my responsibility, or my dependent(s) including but not limited to all co-pays, co-insurance, deductibles, and any items deemed to be noncovered by my insurance company.
4. I hereby authorize the release of my medical information to process and submit claims to Medicare, Medicaid, and/or any other insurance company for Wellstart to receive payments for products authorized and supplied to me.
5. I understand that Wellstart will take all necessary steps under Health Insurance Portability and Accountability Act to protect my Personal Health Information, and I have certain rights to privacy regarding the protection of my Personal Health Information.
6. I understand that I have received copies of the Company's Notice of Privacy Practices, Patient Rights and Responsibilities, Complaint/Grievance Process, Emergency Preparedness Information, Mission Statement, Medicare Supplier Standards, Warranty Information, Rental/Purchase of Inexpensive DME, Hours of Operation and Return Policy in my Quickstart Guide, and I have been provided instructions on how to use my durable medical supplies. I understand that if I have questions, I can call Wellstart and their customer service staff will help me answer any questions that I may have.

Customer Name

Street Address

City State Zip

Date of Birth / / Insurance Name

Policy #

SIGNATURE		DATE	

If someone is authorized to sign on your behalf, the authorized signer must complete the information below:

Name

Relationship to Customer

SIGNATURE		DATE	
Reason for signing			

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