1-800-367-8360

I Acknowledge the Following With My Signature Below:

- I have received with this document a copy of the *Medicare Supplier Standards*, *Customer Rights and Responsibilities*, *Grievance Reporting*, *Emergency Preparedness*, and the *Notice of Privacy Practices* from HDIS, and I understand the content of these documents.
- I have received training and/or documentation on how to use the supplies provided. I understand the owner's manual and warranty will be included when applicable. I understand HDIS will honor all warranties under State law, and replace Medicare covered items that are under warranty free of charge.
- I acknowledge that I am not currently using another supplier for any of my supplies ordered through HDIS.
- I understand my financial responsibilities as they have been explained to me. I understand I will be responsible for any deductibles, coinsurance, or charges denied by my coverage. For additional information on your benefits and your financial responsibility, please go to www.medicare.gov, or contact your Medicaid or insurance provider for plan-specific coverage.
- If HDIS is unable to obtain an Explanation of Benefits from my insurance company, I understand that it is my responsibility to send all Explanations of Benefits to HDIS upon receiving them. Failure to do so could result in a possible delay in shipments.
- I understand that Medicare, Medicaid or my private insurance may require/allow coverage of Medical supplies on a rental basis. I understand that HDIS does not rent any items and will be unable to provide items where rental is required or desired.
- I authorize HDIS to contact my physician to obtain a prescription, contact my insurance provider to verify my benefits and to contact me to discuss my order. I authorize my physician to release my information to HDIS for the purpose of processing and submitting claims to Medicare and/or other insurer(s) for products authorized by me. I authorize HDIS to submit claims on my behalf and to use this signature on file form in lieu of my actual signature on each claim form.

Please answer the following questions so that we may better serve you:

Who is the primary contact person for your account?

_____

What is the telephone number for the primary contact person?

(_____) _____

Who is the emergency contact person for your account?

_____

What is the telephone number for the emergency contact person?

(_____) _____

What is your email address? _____

Signature of Patient or Legal Representative

Signature: _____ ____ **Printed Name**: _____

Relationship (if not patient): _____ ____ **Date:** _____