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EXPRESS VERIFICATION FORM

PHYSICIAN: _____ PHONE: _____ DATE: _____

PATIENT NAME:	Date of Birth:
Insurance Company:	Please Check: Major Med ___ **Workers' Comp___ No-Fault/Auto___
Insurance Phone Number:	Insurance ID/Claim #:
Date of Injury/Accident (if applicable): For Workers' Comp, indicate Employer if known:	Equipment Requested: Tens_____ Lumbar Brace (LSO)_____ Lumbar Traction Unit_____ Thoracic Brace (TLSO)___ Postural Brace (TLSO)___ Knee Brace ___ Cervical Traction Unit _____ OTHER _____

PATIENT NAME:	Date of Birth:
Insurance Company:	Please Check: Major Med ___ **Workers' Comp___ No-Fault/Auto___
Insurance Phone Number:	Insurance ID/Claim #:
Date of Injury/Accident (if applicable): For Workers' Comp, indicate Employer if known:	Equipment Requested: Tens_____ Lumbar Brace (LSO)_____ Lumbar Traction Unit_____ Thoracic Brace (TLSO)___ Postural Brace (TLSO)___ Knee Brace ___ Cervical Traction Unit _____ OTHER _____

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PLEASE FAX YOUR COMPLETED FORM TO 800-211-0404

(**Note: For Workers' Comp patients, attach a completed Prescription Form/Letter of Medical Necessity)

Note: All information provided is confidential and utilized in order to verify coverage and benefits with each patient's insurance company. Information will not be distributed to any other third party provider(s).