Express Relief

# Fax to 1-888-224-5488

# TENS Unit & Supplies Prescription Order & Authorization

**Patient Name:** _____ **Date:** _____

**Physician:** _____ **Tel. Number :** _____

**Diagnosis/Codes:** _____

**PLEASE INCLUDE GARMENT ELECTRODE**: **GLOVE ELBOW SOCK BACK - M L XL XXL 4XL 5XL**
(CIRCLE GARMENT ELECTRODES THAT ARE NEEDED
GLOVE, ELBOW & SOCK ARE 1 SIZE FITS ALL)

4 LEAD TENS UNIT

**The prescription and supplies are for a 4 lead TENS unit, as well as a 2 month disposable TENS supplies which may include leads, electrodes, batteries, conductive gel, garment electrode, as well as other supplies necessary for use as prescribed and are mailed every 2 months, for at least 6 months – DURATION ____6 months ____1 year**

## Physician Signature: _____

***I certify that the above prescribed TENS unit and supplies are medically necessary as indicated by clinical examination findings, as well as the patient's subjective complaints as part of my treatment program for the patient.***

ASSIGNMENT, REQUEST AND AUTHORIZATION

By signing below, I understand, request and authorize Express Relief, LLC., its assignees, and/or its agents (Express Relief, LLC) to ship & supply medical supplies and/or devices, including TENS, EMS, or combo TENS/EMS unit, as well as TENS/EMS medical supplies for a 4-lead unit, every 2 months for at least 6 months or for the time period as prescribed by my physician or requested by me. I also authorize Express Relief, LLC, its assignees, and/or its agents to bill and submit claims for the following codes: A4556 electrodes, A4557 lead wires, A4611 batteries, A4558 conductive gel, EO731 garment electrode, A4595 tens supplies, as well as other HCPCS/CPT codes that coincide with the directions of my physician or per my request, including codes for the instruction & use of the equipment. I understand that Express Relief, LLC may use healthcare provider contractors and agents in order to fulfill such requests and requirements. I authorize Express Relief, LLC to contact me, via mail, electronically &/or telephonically for any reason regarding my account & medical supplies & devices. I understand these supplies will be billed and delivered every 2 months for at least 6 months to receive the greatest results, unless otherwise indicated by me or my physician. Once supplies have been opened, they cannot be returned. I can cancel the supplies at any time by faxed request to 1-844-500-3972

I hereby authorize Express Relief, LLC, its assignees, and/or its agents to supply me with TENS/EMS supplies and or device(s) as prescribed by my physician. I hereby authorize you, my insurance company and/or attorney, to pay directly Express Relief, LLC ("Assignees") such sums as may be due and owing Assignees for disposable supplies given to me, both by reason of accident or illness, and by reason of any other bills that are due Assignees, and to withhold such sums for any disability benefits, medical payments, No Fault benefits, or any other insurance benefits obligated to reimburse or form any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said Assignees, I hereby further give a lien to said Assignees any and all insurance benefits named herein and any and all proceeds of any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignees. This is to act as an assignment of my right and benefits to extent of the Assignees supplies provided to me in accordance with state statute(s).

I hereby grant the release to and from Express Relief, LLC of any/all medical records ito process payment for supplies claims and/or processing of supplies. I authorize all health care providers, physicians, hospitals, medical staff and attorneys to furnish any and all information and medical records regarding me to Express Relief, LLC,. I authorize Express Relief, LLC to release any and all information and medical records regarding me, to those parties that are necessary to process and/or collect from my insurance claim(s), and/or other claims related to my healthcare supplied & services.

In the event my insurance company obligated to make payments to me upon charges made by Assignees for supplies, refuses to make such payments, upon demand by me or Assignees, I hereby assign and transfer Assignees any and all causes of action that I might have or that exist in my favor against such company and authorize assignees to prosecute said causes of action either in my name or in Assignees' name, and further I authorize Assignees to compromise, settle, or resolve said claim or cause of action as they see fit. In due, valid and good consideration I hereby indemnify and hold harmless Express Relief, LLC and its assignees harmless from any and all actions and/or claims in regard to the usage and outcomes from TENS/EMS equipment and/or all medical supplies & devices provided to me and its billing of payer(s). To avoid exhaustion of insurance benefits while Assignees pursue its right under this assignment, I direct my insurance company to set aside and place in escrow any disputed amount or reductions until the resolution of such dispute. I authorize Assignees to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization. I hereby understand and acknowledge that Assignees comply and make every effort to comply with all national, state and local privacy act regulations and requirements and have read their privacy policies.

**PATIENT SIGNATURE** **DATE**

**PATIENT INFORMATION SHEET**


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**PATIENT NAME :**_____

**ADDRESS :**_____**CITY/STATE/ZIP**_____

**PHONE # :**_____

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**PRIMARY AUTO INSURANCE COMPANY (COMPANY THAT WILL BE BILLED FOR TENS SUPPLIES )**

**INS. CO. NAME :**_____**NAME OF INSURED :**_____

**ADDRESS :**_____**CITY/STATE/ZIP :**_____

**CLAIMS ADJUSTER NAME :**_____**INS. TEL. NUMBER :**_____

**POLICY NUMBER :**_____**CLAIM NUMBER :**_____

**DATE OF ACCIDENT :**_____

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**ATTORNEY INFO (REPRESENTING YOU FOR YOUR ACCIDENT, LEAVE BLANK IF YOU DO NOT HAVE ONE)**

**ATTORNEY NAME :**_____**TELPHONE NUMBER :**_____

**ADDRESS :**_____**CITY/STATE/ZIP :**_____

**FAX NUMBER :**_____ **CONTACT NAME :**_____

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