Piedmont Medical SOLUTIONS

2255 Lewisville Clemmons Road
Suite F
Clemmons, NC 27012
Phone: 336-602-1668

DME PRODUCT DELIVERY FORM

Patient Name:	Date Of Delivery:
Patient Address:	☐ Initial Receipt of Product ☐ Follow-up
Phone #:	INSURER(S):

ASSIGNMENT OF BENEFITS / WARRANTY POLICY

☐ **ASSIGNMENT OF BENEFITS**

I request that payment of Medicare, Medicaid, Medicare Supplemental or Other Insurance benefits be made on my behalf to **Piedmont Medical Solutions, Inc.** for any medical supplies furnished to me by **Piedmont Medical Solutions, Inc.** I authorize any holder of medical information about me to release to **Piedmont Medical Solutions, Inc.,** my physician(s), caregiver, CMS, its agents and my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

☐ **WARRANTY POLICY**

Every product sold or rented by our company carries a 1-year manufacturer's warranty. Piedmont Medical Solutions, Inc. will notify all beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. We will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where a manual is available.

NO RETURNS WILL BE ACCEPTED.

Please contact us at 336-602-1668 if you experience any problems.

Hours of Operation: 8:30 am to 5:00 pm

➢ **WE ESTIMATE YOUR COINSURANCE / PATIENT BALANCE TO BE _____ %.**

DME PRODUCT

DEVICE(S) / HCPCS CODE(S):	SERIAL #:
MAKE/MODEL:	MANUFACTURER:

CHOOSE TYPE OF PRODUCT

☐ SPINAL ORTHOSIS	☐ UROLOGY (CATHETERS, ETC.)	☐ POWER WHEELCHAIR	☐ KNEE SCOOTER
☐ KNEE ORTHOSIS	☐ TENS (NERVE STIMULATOR)	☐ POWER SCOOTER	☐ WALKING BOOT
☐ SHOULDER ORTHOSIS	☐ TENS SUPPLIES (ELECTRODES & LEAD WIRES)	☐ BREAST PUMP	☐

ADDITIONAL INSTRUCTIONS: The following has been given and discussed to the patient/caregiver:

☐ Rights & Responsibilities	☐ Patient Plan of Care	☐ Cleaning, Use & Maintenance of Equipment
☐ Privacy Notice	☐ Equipment Instructions	☐

The products and/or services provided to you by Piedmont Medical Solutions, Inc. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

FOLLOW UP / DISCHARGE

☐ FOLLOW UP REQUIRED ☐ FOLLOW UP RECOMMENDED	FOLLOW UP NOTES:

I HAVE READ, RECEIVED AND/OR BEEN INSTRUCTED IN DETAIL ON THE ITEMS MARKED ABOVE.
(If Patient unable to sign, authorized person complete.)

PATIENT SIGNATURE:	**DATE:**
AUTHORIZED PERSON: Relationship to Patient:	DATE:
COMPANY REPRESENTATIVE:	**DATE:**