
NAME

ADDRESS

CITY

STATE

ZIP

DATE OF BIRTH

SOCIAL SECURITY NUMBER (OPTIONAL)

DAYTIME PHONE

EVENING PHONE

MOBILE PHONE

EMAIL

OCCUPATION

Primary Care Physician (PCP)

PCP NAME

LOCATION/HOSPITAL

PHONE

Emergency Contact

NAME

RELATIONSHIP TO PATIENT

PHONE

Insurance Information

Please note that CORAL is generally an Out-Of-Network provider. We are happy to file insurance on your behalf for custom garments (garments measured and made specifically for you). IN order to continue to stock and offer affordably priced garments such as Ready-To-Wear, we generally do not submit insurance claims for off the shelf compression garments. In those instances, upon receipt of your payment, we provide you with a "Paid" invoice that includes diagnosis and treatment/garment codes which is important for you to submit to the insurance company in order for your claim to be considered by your insurance carrier. Please ask us how we can help you with this process.

INSURANCE COMPANY

NAME OF INSURED

RELATIONSHIP TO PATIENT

PATIENT ID NUMBER

GROUP ID NUMBER

My signature acknowledges that I have received the HIPAA Notice of Privacy Practices. "I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment."

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE