Required for the Pelvic Floor Electrical Stimulator System (E0740)

Please complete this form and fax to **S.A. Maher, Inc. at 440-777-5094 (FAX).**

If you have any questions, please call us at **440-777-5544 or email samaherinc@yahoo.com**

NOTE: A copy of all pertinent medical Records must accompany this form

(Required for insurance Reimbursement)

Physician information:

Physician name:	**Phone:**
Physician's Address:	**Fax:**
NPI:	**Please circle: Diagnosis: N39.46-Urge Incontinence** **N39.3 Stress Incontinence (Female/Male)** **N39.46 Mixed Incontinence of feces** **Other :_____**

Patient Information:

Patient name:	**Date of Birth:**
Street Address:	**Social Security Number:**
City, State & Zip Code:	
Home Phone:	**Cell Phone:**
Name of Spouse:	**Emergency Contact Phone Number:**
Employer:	**Business Phone:**
Onset of Symptoms:	**Previously owned Pelvic Floor Stimulator: Yes / No** **If yes when?**
Medications/ Treatments:	

Medicare Information:

Primary Insurance:	**Insurance Co. Phone:**
Id/ Policy #:	**Group #:**

Supplemental Insurance Information:

Secondary Insurance Co.:	**Phone:**
Id / Policy # :	**Group #:**
Subscriber Name:	**Subscribers Date of Birth:**
Subscribers Social Security Number:	**Subscribers Employer:**

Patient's Signature:_____ Date:_____

I am responsible for payment of purchase fees that are not paid for or declined for payment by my insurance carrier. If I cannot meet these financial obligations, I will contact S.A. Maher, Inc. at 440-777-5544. I request that my payment from my Medical Insurance Program be made directly to: S.A. Maher, Inc., P.O.BOX 38306, Olmsted Falls, Ohio 44138. I authorize release of medical information when needed. I understand the charges for a Pelvic Floor Stimulation Unit is $845.00.