HEARTS ENTERAL, LLC.
11 Rande Dr.
Wayne, NJ 07470
Tel: (973) 706-6704,
Fax: (973) 387-1223
Email: raenettef@compassionworksmrs.com
Web: www. heartsenteral.com
Web: www.compassionworksmrs.com (sister company)

HIPAA Compliant
(Health Insurance Portability and Accountability Act of 1996)

Coverage Assistance Form

PATIENT INFORMATION				
FIRST NAME	MIDDLE INITIAL	LAST NAME		
DATE OF BIRTH	AGE	SS # (Optional)	GENDER	
/ /			□ MALE □ FEMALE	
STREET ADDRESS	APT#	CITY	STATE	ZIP
EMAIL ADDRESS	EMPLOYMENT STATUS			
	□ CHILD □ EMPLOYED F/T □ EMPLOYED P/T □ UNEMPLOYED □ DISABLED □ SELF-EMPLOYED □ STUDENT □ OTHER			
PHONE	WORK NUMBER	OTHER PHONE		

GENETIC DISORDER			
DISORDER	CURRENT MEDICAL FOOD	AMOUNT PER DAY	CURRENT DME/PHARM

CLINIC INFORMATION			
DIETITIAN/PHYSICIAN	CLINIC	PHONE #	FAX #

RESPONSIBLE PARTY / PARENT / CAREGIVER (GUARANTOR) INFORMATION			
RELATIONSHIPTO PATIENT: □ SELF □ CHILD □ SPOUSE □ PARENT □ OTHER _____			
LAST NAME	FIRST NAME	MIDDLE INITIAL	PHONE NUMBER #

PRIMARY INSURANCE INFORMATION			
INSURANCE NAME	PHONE NUMBER	MEMBER ID #	GROUP #
MEMBER NAME	MEMBERS DATE OF BIRTH	RELATIONSHIP TO MEMBER	

SECONDARY INSURANCE INFORMATION			
INSURANCE NAME	PHONE NUMBER	MEMBER ID #	GROUP #

Authorization for Release of Health Information: *I HEREBY AUTHORIZE RELEASE OF HEALTHCARE INFORMATION. This information contained herein may be shared to Hearts Enteral, LLC and its affiliates for quality purposes to ensure that the necessary resources are available to service you for medical food reimbursement support and supplier distribution. Such information is furnished in compliance with* ***HIPAA*** *to allow for the best service.* ***I also understand and agree to Hearts Enteral's Notice of Privacy Practices..*** *Nonetheless, if you do not wish for this information to be shared with Hearts Enteral, LLC. call (973) 706-6704 and our HIPAA Privacy Officer will assist you with this request and ensure that the information is not shared.*

Signature of applicant: _____ **Date:** _____

Representative of applicant: _____ **Date:** _____

Representative Title:_____

IMPORTANT: PLEASE FAX , MAIL (above) OR EMAIL COMPLETED FORM TO: HEARTS ENTERAL, LLC., ATTN: MICHAEL MAGZANIAN, COO, FAX (973) 387-1223 OR EMAIL raenettef@compassionworksmrs.com.

PLEASE ATTACH A PERSCRIPTION, LETTER OF MEDICAL NECESSITY and copy of insurance card (front & back)* * *