Patient & Clinic Information

PATIENT DOB ___ ___ / ___ ___ / ___ ___ Sex_____(M/F)

PATIENT NAME_______________________________________

☐ WORKERS COMPENSATION ☐ PERSONAL INJURY

Attach Complete Demographic sheet with Complete Work Comp or Attorney Info

Attorney / Adjuster NAME:_________________________

Attorney / Adjuster PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

MOBILE PHONE(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

PHONE(___ ____ ____) ____ ____ ____ - ____ ____ ____ ____

DATE OF INJURY: ____ ____ / ____ ____ / ____ ____

INSURANCE____

EMPLOYER____

CLAIM #____________________________________

INSURANCE PHONE (_______) ___ ___ ___ -___ ___ ___ ___

PHYSICIAN NAME ____

FACILITY NAME ____

FACILITY ADDRESS ______________________________________

CITY ____

STATE ____ ____ ZIP ____ ____ ____ ____ ____

PHONE (___ ____ ____) ____ ____ ____ - ____ ____ ____ ____

FAX (___ ____ ____) ____ ____ ____ - ____ ____ ____ ____

NPI # ____

OFFICE CONTACT _______________________________________

PLEASE FAX COMPLETED FORM TO:
A&O Medical, Authorized Distributor
Fax: (727)245-8442
Email: orders@aomedical.net
Phone: (941) 739-0155

Please Complete All Appropriate Boxes

Physician Prescription

ICD 10:________, ________, ________ **Surgery Date:_________** **Side** ☐ Left ☐ Right **Body Part**

☐ Knee ☐ Shoulder ☐ Elbow ☐ Lumbar ☐ Cervical ☐ Hand/Wrist ☐ Foot/Ankle ☐ Other_________

☐ **Tru Stim PRO Bundle NMES E0745, With Anatomic Garment E0731**

"DO NOT SUBSTITUTE" **Supplies – A4595:** ***Requires a quantity of 2 packs of supplies per month***

☐ 2 Month ☐ 4 Month

PHYSICIAN'S SIGNATURE:____DATE____ ____ / ____ ____ / ____ ____

PHYSICIAN'S PRINTED NAME: ____

***Please attach any clinical notes to expedite this request.**

Billing Contact; A&O Medical 941-739-0155 ***Sales Rep:*** Cory Steiner (800) 366-8051