

ORDER FORM

Utah Medical Products, Inc.
Phone: 1-800-533-4984 — Fax: (801) 566-2062

Address Phone # City State Zip Employer Phone # For MEDICARE CLAIMS ONLY: Copies of Insurance Cards (both sides) and Letter of Medical Necessity MUST accompany this order Medicare claims cannot be filled without those items Formary insurance Group # ID/Claim # Formary insurance Group # ID/Claim # Formary insurance Company Formary insurance Group # ID/Claim # Formary insurance Group # ID/Claim # Formary insurance Phone # Formary insurance Group # ID/Claim # Formary insurance Group # ID/Claim # Formary insurance Phone # Formary insurance Group # ID/Claim # Formary insurance Phone # Formary insurance Group # ID/Claim # Formary insurance Phone # Formary insurance Group # ID/Claim # Formary insurance Phone # HCPCS Code: E0740 Diagnosis: Urge Incontinence Stress Incontinence Mixed Incontinence Petric Floor Dysfunction Other Physician Signature Physician's Name Date X X X Flynician Address Phone # Flynician Address Phone # Address Phone # Address Phone # The Liberty System is subject to shipping/handling charges and state tax (if applicable). 2. parent Payment must be made in full before the Liberty System can be shipped (with the exception of applicable Medicare Address) Phone # With my signature and initials below, I agree: 1. That my order for the Liberty System is subject to shipping/handling charges and state tax (if applicable). 2. parent Payment must be made in full before the Liberty System can be shipped (with the exception of applicable Medicare coverage, Utah Medical Products, Inc. (UTIMD) is authorized to forward my order to a Medicare supplier. 4. If I have private insurance, that I am completely responsible for making the insurance claim with my insurance company. 5. I authorize the release of applicable medical information about me by any holder of this in				
Employer For MEDICARE CLAIMS ONLY: Copies of Insurance Cards (both aides) and Letter of Medical Necessity MUST accompany this order Medicare claims cannot be filled without these items Firmary Insurance Company Firmary Insurance Address Group # ID/Claim # Phone # Insurance Cards (both aides) and Letter of Medical Necessity MUST accompany this order Medicare claims cannot be filled without these items Firmary Insurance Address Group # ID/Claim # Secondary Insurance Company Secondary Insurance Address I am prescribing: The Liberty* PFS System (PFS-200) with: Company	ame	Date of Birth (n	nm/dd/yyyy)	
Employer Phone # FOR MEDICARE CLAIMS ONLY: Copies of Insurance Cards (both sides) and Letter of Medical Necessity MUST accompany this order Medicare claims cannot be filed without these items Finnary Insurance Group # ID/Claim # Company Finnary Insurance Phone # Address Secondary Insurance Phone # Address Secondary Insurance Phone # Address I am prescribing: The Liberty* PFS-2000 with: Vaginal Exerciser (PFS-042) Rectal Exerciser (PFS-043) Diagnosis: Urge Incontinence Stress Incontinence Mixed Incontinence Pelvic Floor Dysfunction Other Physician Signature Prescribing Physician's Name Date X Phone # Ship to City State Zip Address Phone # With my signature and initials below, I agree: 1. That my order for the Liberty System is subject to shipping/handling charges and state tax (if applicable). 2. Pariets Payment must be made in full before the Liberty System can be shipped (with the exception of applicable Medicare benefits) coverage). 3. That, if I have Medicare coverage, Utah Medical Products, Inc. (UTMD) is authorized to forward my order to a Medicare supplier. 4. If I have private insurance, that I am completely responsible for making the insurance claim with my insurance company. 5. I authorize the release of applicable medical information about me by any holder of this information to the Centers for Medicare and Mediciad Services or its agents, as required to determine the benefits payable for related products or services. 6. That until I have made all required payments for the Liberty System, UTMD or the Medicare supplier own the product. 7. Patient I have made all required payments for the Liberty System of the System of System of Spip and endedicare overage and/or payment. Bustinence benefit eligibility and quotes provided to me by UTMD are NOT a guarantee of coverage and/or payment. Bustinence benefit eligibility and quotes provided to me by UTMD are NOT a guarantee of coverage and/or payment.	ddress		Phone #	
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Address Secondary Insurance Group # ID/Claim # Company		Group #	ID/Claim #	
Company Secondary Insurance Phone #	•		Phone #	
Lamp prescribing: The Liberty® PFS System (PFS-200) with:	•	Group #	ID/Claim #	
The Liberty® PFS System (PFS-200) with: daginal Exerciser (PFS-041) Extended Handle Vaginal Exerciser (PFS-042) Rectal Exerciser (PFS-043) Diagnosis: Urge Incontinence Stress Incontinence Mixed Incontinence Pelvic Floor Dysfunction Other			Phone #	
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I understand and agree to the Patient Purchase Agreement above and authorize my credit card to be charged according			CVV.	
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