amoena

AETNA POST MASTECTOMY

CONFIRMATION OF BENEFITS FORM

COMPLETE ALL SECTIONS AND FAX TO AMOENA USA CORP AT: 1-877-726-7702 Phone: 1-800-811-5659

ICD 10:

SECTION I – RETAILER INFORMATION (Retailer to Complete)			
Date of Verification Request:			
Retailer Store Name:		Amoena Account #:	
Phone:		Fax:	

SECTION II – MEMBER INFORMATION (Retailer to Complete)			
Last Name		First Name	
Date Of Birth		Member ID	
Group #		Phone #	
Address:		City, State, Zip	

SECTION III – PHYSICIAN INFORMATION (Retailer to Complete)			
Primary Care Physician		Physician ID#	
Physician Phone Number		Rx attached?	YES____ NO_____

SECTION IV - PRODUCT INFORMATION (Retailer to Complete)			
PLEASE LIST NON UPGRADEABLE BRA AND FORM SHOWN TO MEMBER			
Bra:		Form:	
PLEASE LIST ITEMS TO BE PURCHASED			
HCPC		Quantity	
HCPC		Quantity	
HCPC		Quantity	
HCPC		Quantity	

SECTION V – APPROVAL CONFIRMATION (Amoena USA Corp. to Complete)

AUTHORIZATION OF BENEFIT NOT VALID AFTER 30 DAYS

Deductible Due	$	**Deductible Start: _____ Deductible Remaining: _____** **Co-insurance: _____% L8015: _____ L8000 _____ L8030 _____** **L8020 _____ L8032 _____ L8001 _____ L8002 _____**
Co-pay/Coins Due	$	
TOTAL DUE FROM MEMBER AT TIME OF SERVICE	$	

_____ Amoena Verifications Coordinator:	_____ Date:	_____ Verification Valid Through:

SECTION VI – ASSIGNMENT OF BENEFITS (Patient to Complete)

I request that payment of authorized medical insurance benefits be made directly to Amoena on any unpaid bill for medical supplies and equipment for the period of medical necessity prescribed by my physician, and listed on the invoice. In addition, I authorize any holder of medical or other information to release any data about me needed to determine benefits for related services to Amoena USA Corp**. I understand that my insurance may have a limit or dollar allowance for the items listed above. If any item I have chosen to purchase is not covered by my insurance, or includes a non-covered upgrade, I will be responsible for payment of the non-covered upgrade, as specified above, in addition to any applicable copayment, coinsurance or deductible. I am aware that the total amount due is subject to final payment processing made by my insurance to Amoena USA Corp.**

_____ _____

Patient's Signature Date

I, _____, the undersigned confirm that I have received all products identified on this Confirmation Of Benefits Form and am awaiting receipt of no additional product.

_____ _____

Patient's Signature Date

Amoena to Date Stamp all Sections	Date Stamp Section I – III	Date Stamp Section IV - V	Date Stamp Section VI Claim is complete – Pay retailer

Revised November 1, 2017

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AETNA COMPRESSION, WIGS & BREAST PUMPS ONLY

CONFIRMATION OF BENEFITS FORM
COMPLETE ALL SECTIONS AND FAX TO AMOENA USA CORP AT:
Fax #: 1-877-726-7702 **Phone #: 1-800-811-5659**

ICD 10:

SECTION I – RETAILER INFORMATION (Retailer to Complete)			
Date of Verification Request:			
Retailer Store Name:		Amoena Account #:	
Phone:		Fax:	
SECTION II – MEMBER INFORMATION (Retailer to Complete)			
Last Name		First Name	
Date Of Birth		Member ID	
Group #		Phone #	
Address:		City, State, Zip	
SECTION III – PHYSICIAN INFORMATION (Retailer to Complete)			
Primary Care Physician		Physician ID#	
Physician Phone Number		Rx attached?	YES____ NO_____

SECTION IV - PRODUCT INFORMATION (Retailer to Complete)					
PLEASE LIST ITEMS TO BE PURCHASED					
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$
HCPC		Quantity		Charges (EACH)	$

SECTION V – APPROVAL CONFIRMATION (Amoena USA Corp. to Complete) **AUTHORIZATION OF BENEFIT NOT VALID AFTER 30 DAYS**		
Deductible Due	$	**Deductible Start:** _____
Co-pay/Coins Due	$	**Deductible Remaining:** _____ **Coinsurance:**_____ **%**
TOTAL DUE FROM MEMBER AT TIME OF SERVICE	$	
_____ Amoena Verifications Coordinator	_____ Date:	_____ VERIFICATION VALID THROUGH

SECTION VI – ASSIGNMENT OF BENEFITS (Patient to Complete)

I request that payment of authorized medical insurance benefits be made directly to Amoena on any unpaid bill for medical supplies and equipment for the period of medical necessity prescribed by my physician, and listed on the invoice. In addition, I authorize any holder of medical or other information to release any data about me needed to determine benefits for related services to Amoena USA Corp**. I understand that my insurance may have a limit or dollar allowance for the items listed above. If any item I have chosen to purchase is not covered by my insurance, or includes a non-covered upgrade, I will be responsible for payment of the non-covered upgrade, as specified above, in addition to any applicable copayment, coinsurance or deductible. I am aware that the total amount due is subject to final payment processing made by my insurance to Amoena USA Corp.**

_____ _____
Patient's Signature Date

I, _____, the undersigned confirm that I have received all products identified on this Confirmation Of Benefits Form and am awaiting receipt of no additional product.

_____ _____
Patient's Signature Date

Amoena to Date Stamp all Sections	Date Stamp Section I – III	Date Stamp Section IV - V	Date Stamp Section VI Claim is complete – Pay retailer

Revised November 1, 2017