



**MOUNTAIN
MEDICAL SUPPLY**

704 Jefferson St
Paducah, KY 42001
Phone: (877) 492-2704
Fax: (877) 492-2716

Patient Acknowledgment

I authorize Mountain Medical Supply to submit request for payment directly to the Department of Labor insurance program, on my behalf, for the equipment and services furnished me during the time it is in my possession.

I authorize Mountain Medical Supply to use my Personally Identifiable Information (PII) and Protected Health Information (PHI), to include my demographic information, Date of Birth, Social Security Number, Insurance Card ID Number, doctor's or nurse's clinic/hospital notes, charts, test results, and prescriptions, as needed to provide durable medical equipment and supplies prescribed by my doctor and requested by me or someone that has been given permission to act on my behalf, for the purposes of gaining authorization for requested equipment and supplies and to submit payment requests to my Department of Labor insurance.

Today's Date: _____

Date of Birth: _____

First Name: _____

Middle Initial: _____

Last Name: _____

Suffix: _____

Signature: _____

Patient Representative Name (if signing for patient): _____

Relationship to Patient: _____