MOUNTAIN MEDICAL SUPPLY

Phone: (877)492-2704
Fax: (877) 492-2716
Email: info@mmsdme.com

Patient Acknowledgment

I authorize Mountain Medical Supply to submit request for payment directly to the 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 insurance program. This permission remains in effect until I notify Mountain Medical Supply to terminate and cancel immediately.

Today's Date: _____ **Date of Birth:** _____

First Name: _____ **Middle Initial:** _____

Last Name: _____ **Suffix:** _____

Signature: _____

Patient Representative Name (if signing for patient): _____

Relationship to Patient: _____