CIGNA Healthcare Compression

CONFIRMATION OF BENEFITS FORM
COMPLETE ALL SECTIONS AND FAX TO AMOENA USA CORP AT:
Fax #: 1-800-229-5334 **Phone #: 1-800-811-5659**

ICD 10:

SECTION I – RETAILER INFORMATION (Retailer to Complete)			
Date of Verification Request:			
Retailer Store Name:	Body Works Custom Compression	Amoena Account #:	C0028
Phone:	800-331-2710	Fax:	703-852-4371

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)	$

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.**

x _____ _____
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.

x _____ _____
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