



1664 Larkin Williams Rd. • Fenton, MO 63026  
 (314) 821-7355 • (800) 950-6020  
 Hours: Monday - Friday, 9a - 5:30p  
 Order Online 24/7 at www.stlmedical.com

## CUSTOMER INFORMATION FORM

Please provide the requested information necessary for us to submit claims to your insurance company on your behalf. An asterisk (\*) denotes required information.

* Patient Name _____	Acct. # _____
* Address _____	* Date of Birth _____
* City, State, Zip _____	* Sex ( ) M ( ) F
* Phone ( ) _____	* SSN _____
Contact Person (if other than patient) _____	Contact Phone ( ) _____

* Ordering Doctor's Name _____
Address _____
City, State, Zip _____
* Phone ( ) _____
* NPI # _____
Diagnosis and/or ICD-9 codes _____
_____

### BILLING INFORMATION

#### PRIMARY INSURANCE

* Name _____	
* Address _____	
* City _____ * State _____ * Zip _____	
* Phone ( ) _____	
* ID # _____	* CO-PAY _____%
* Group # _____	* Deductible \$ _____

#### SECONDARY INSURANCE

Name _____	
Address _____	
City _____ State _____ Zip _____	
Phone ( ) _____	
ID # _____	CO-PAY _____%
Group # _____	Deductible \$ _____

In addition to this form, some products purchased require a Certificate of Medical Necessity or a prescription to be completed by your physician before claims can be filed. Please call us if you are unsure if the product you are purchasing requires this.

### SIGNATURE ON FILE AGREEMENT

Your signature below signifies your understanding that your insurance company (Medicare or private insurance) may not cover the items you purchased or may not cover them at 100%. St. Louis Medical Supply cannot guarantee coverage or reimbursement amounts on any item purchased. You may be responsible for any charges not covered by your insurance policy. A service charge of 1-1/8% per month 18%APR will be added to all overdue accounts. You are also liable for all legal and collection fees.

I request that payment of authorized medical benefits be made for any products furnished to me by St. Louis Medical Supply. These payments are to me, or on my behalf, to St. Louis Medical Supply.

\_\_\_\_\_

\* Patient's Signature

\_\_\_\_\_

\* Date