D&J Medical
ORTHOTICS PROSTHETICS COMPRESSION

Patient Name: Insurance ID:

Note: You need to make a choice about receiving your Orthotic, Prosthetic and/or Compression services.

We expect your insurance company will not pay for the item(s) or service(s) that are described below. Your insurance company does not pay for all of your health care costs. Your insurance company only pays for covered items and services when your insurance company's guidelines are met. The fact that your insurance company will not pay for a particular item or service does not mean that you should not receive it. **There are good reasons your doctor may have recommended it. At this time, your insurance will not pay for the following items:**

Item or Service:
Reason:

The purpose of this form is to help you make an informed choice about whether or not to receive the items or service, knowing that you will have to pay for them yourself.

- Ask us to explain, if you do not understand why your insurance company will not pay.
- Ask how much these items or services will cost you (Estimated Cost: $)

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.

☐ **Option 1: Yes, I want to receive these items or services.**
I understand that my insurance company may not cover the items that I have been prescribed. My insurance company will not be billed. I agree to make payment arrangements for the items prior to ordering.

☐ **Option 2: Yes, I want to receive these items or services.**
I understand that my insurance company is not expected to pay for these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items and services and that I may have to pay while insurance company is making its decision. If my insurance company does pay, you will refund me any payments due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay either out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision directly.

☐ **Option 3: No, I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and I have no appeal rights.

Signature of patient or person acting on patient's behalf: _____ **Date:** _____

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