SunMED Medical Solutions

Request for Insurance Benefit Eligibility Check

Fax to **800-715-5422** with required attachments for benefit eligibility.
Retail transactions can be done online at www.SunMEDCHOICE.com or by calling **800-714-7434**

Customer

From:_____ To:_____
Name:_____ Facility:_____
Phone:_____ Email:_____ Fax:_____
☐ Ship to Patient ☐ Ship to me/address:_____

Patient

Patient Name:_____DOB_____/____/_____
Cell:_____ Email:_____ Other:_____

Please furnish an email so SunMED can convey coverage in writing for your patients records.

Attach Required:

☐ Patient Demographics
☐ Copy of Insurance card front and back
☐ Secondary Insurance name _____
Policy: _____ Group: _____
☐ Prescription is attached OR Enter Ordering MD Full Name: _____
Phone # _____ Fax#_____

Clinical

Diagnosis (required as coverage is based on diagnosis)
ICD-10 Code(s): _____, _____, _____, _____
Treating: ☐ Upper Left ☐ Upper Right ☐ Upper Bilateral
☐ Lower Left ☐ Lower Right ☐ Lower Bilateral
Other:_____

Order. Complete A or B

A. Verify insurance for the following products:

☐ Pump
☐ Bandaging Date needed to start treatment ____/____/_____
☐ Elastic Garments Date needed for maintenance ____/____/_____
Brand_____ Style name_____ mmHG_____ Size_____ Color_____
☐ In-Elastic Garments Date needed for maintenance ____/____/_____
Brand_____ Style name_____ mmHG_____ Size_____ Color_____

B. I am undecided, please verify for the following.

*Exact out of pocket cost cannot be calculated until a product is selected.

Upper Extremity

☐ Custom ☐ Ready to Wear

Compression:
☐15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50

Glove ☐ Right ☐ Left
Gauntlet ☐ Right ☐ Left
Sleeve ☐ Right ☐ Left
Other_____

Lower Extremity

☐ Custom ☐ Ready to Wear

Compression:
☐15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50

Knee High ☐ Right ☐ Left
Thigh High ☐ Right ☐ Left
Chaps ☐ Right ☐ Left
Pantyhose ☐ Right ☐ Left
Other: _____