



National Orthotics and Prosthetics Company
A Boston Brace Company

NOPCO is an independent private company, which provides orthotic and prosthetic services to patients of the hospital. Please complete and sign this form so we may verify your insurance coverage. We will also verify the amount of coverage to expect on the items prescribed by your physician. Please remember that until insurance processes the claim the amount verified is only an estimate. All deductibles and co-pays are due upon fitting.

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Sex: M / F Weight _____ lbs Height _____ ft _____ in
Street Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____
Email: _____ Social Security#: _____
(Optional)
Referring Physician: _____

PARENT/ GUARANTOR INFORMATION (primary insurance holder if different from patient)

Subscriber Name: _____ Date of Birth: _____
Insurance Co: _____ Social Security#: _____

WORKER'S COMPENSATION (IF APPLICABLE)

Employer: _____ WC Insurance Co: _____
Address: _____ Phone: _____
Policy#: _____ Claim#: _____ Date of Accident: _____
Contact Person: _____

BENEFITS, MEDICAL INFORMATION RELEASE AUTHORIZATION & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY :

I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsible party I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I will assume responsibility for any approved co-payment and/or deductible amounts for covered procedures and the full charge for non-covered or denied procedures. I agree to notify NOPCO immediately of any changes in insurance coverage or status.

Signature Print Name Date