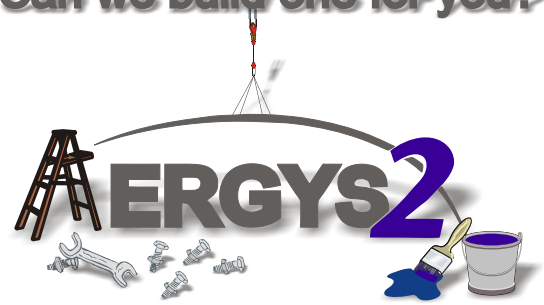
Can we build one for you?



Send

Reset

Patient Information

Therapeutic Alliances can assist you in getting reimbursement for the ERGYS. Please fill in the appropriate sections of this form and mail or fax the form back to Therapeutic Alliances Inc.

Successful reimbursement usually requires:

1. A prescription from your physician which typically reads "ERGYS Rehabilitation System for home use."
2. A letter of medical necessity from your physician. Therapeutic Alliances can offer samples and suggestions for this letter.
3. Information on this form so that Therapeutic Alliances can make contact with your insurance company. A contact name and telephone number at your insurance company provide the best starting point.

Basic Patient Information

FIRST NAME LAST NAME

ADDRESS

ADDRESS

CITY STATE ZIP

DATE OF BIRTH MM/DD/YY SS NUMBER

HOME TELEPHONE WORK TELEPHONE

INJURY LEVEL HEIGHT WEIGHT

Is the condition related to employment? YES NO

Date of injury or symptoms

Did the injury result from an automobile accident? YES NO

State in which automobile accident occurred

Did injury result from other accident? YES NO

FILL IN OTHER SIDE OF THIS FORM IF APPLICABLE

PRIMARY INSURANCE

INSURANCE COMPANY NAME

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY OR GROUP NUMBER

INSURANCE ID NUMBER

POLICY HOLDER'S NAME----------

FIRST NAME LAST NAME

INSURANCE COMPANY CONTACT-----

FIRST NAME LAST NAME

OFFICE TELEPHONE FAX TELEPHONE

I, the undersigned, authorize payment of medical benefits to Therapeutic Alliances Inc. for services or products rendered. I authorize the release of any medical or other information for the express purpose of processing my claim.

signature date

Therapeutic Alliances Inc.
333 North Broad Street
Fairborn, Ohio 45324 USA

(937) 879-0734 • (937) 879-5211 (fax) • www.ERGYS.com • info@ERGYS.com

Referring Physician

FIRST NAME LAST NAME

ADDRESS

ADDRESS

PHYSICIAN'S U-PIN# SPECIALTY

CITY STATE ZIP

OFFICE TELEPHONE FAX TELEPHONE

REFERRING HOSPITAL

DIAGNOSIS

SECONDARY INSURANCE

INSURANCE COMPANY NAME

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY OR GROUP NUMBER

INSURANCE ID NUMBER

POLICY HOLDER'S NAME----------

FIRST NAME LAST NAME

WORKER'S COMPENSATION #

EMPLOYER AT TIME OF INJURY

INSURANCE COMPANY CONTACT-----

FIRST NAME LAST NAME

OFFICE TELEPHONE FAX TELEPHONE

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