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: ______________________

*Street Address: ______________________

*City: ______________________ State: ____________ Zip: ______________________

*Phone: ______________________

*NPI #: ______________________

*Diagnosis a/or ICD-9 Codes: ______________________

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BILLING INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
*Name: ______________________	*Name: ______________________
*Address: ______________________	*Address: ______________________
*City: ____________ *State: ________ *ZIP: ________	*City: ____________ *State: ________ *ZIP: ________
*Phone: ______________________	*Phone: ______________________
*ID #: ______________ *CO-PAY: ________%	*ID #: ______________ *CO-PAY: ________%
*Group #: ______________ *Deductible $________	*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%. Nextra Health 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 Nextra Health. These payments are to me, or on my behalf, to Nextra Health.

*Patient's Signature: ______________________ *Date: ______________________

NEXTRA HEALTH

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