Authorization of Billing & Warranty Statement

This form is required to bill on your behalf

My signature and date in the box below authorizes each of the following:

1. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s) on my behalf.
2. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

The Diabetic Shoppe and/or any of their corporate affiliates to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for therapeutic shoes provided.

I have received ____ individual shoes (style:__________)"extra depth" shoes & ____ individual heat-molded inserts (A5512 compliant), or ____ individual full contact custom inserts made from a cast of my foot (A5513 compliant). I am satisfied with the fit and authorize Medicare & my supplemental insurance carrier to pay The Diabetic Shoppe directly. I understand that Medicare pays for up to one pair of shoes (2 individual) & 3 pair inserts (6 individual) per calendar year. I understand that I am responsible for any deductible & unpaid balance that Medicare or my co-insurance does not cover. **I have not received any other shoes or inserts under this plan from any other supplier in this calendar year.**

Patients Warranty Statement

The Diabetic Shoppe will accept returns of any shoes, for any reason, within 30 days of the shoes being dispensed. If, within 30 days, the shoes do not fit properly, The Diabetic Shoppe will replace them, at no Charge, with properly fitted shoes. Shoes that have been dispensed for a period of over 30 days will only be exchanged or credited at the sole discretion of The Diabetic Shoppe. **Any shoe that is returned must be returned in the original shoe box with a signed copy of the warranty.**

I have received the Medicare Supplier Standards, Notice of Health Information Privacy Policy, Patient's Rights & Responsibilities and understand the break-in procedures for shoes. I have also been informed of my financial obligation and agree to pay all amounts not covered by my insurance.

SIGN, DATE AND RETURN ENTIRE FORM IMMEDIATELY!
In order for us to bill Medicare and/or other insurance for your therapeutic shoes, this form must be completed, signed, dated and returned immediately.

I authorize The Diabetic Shoppe and/or any of their corporate affiliates to directly bill Medicare, Medicaid, Medicare Supplemental, or other insurer(s) on my behalf, for therapeutic shoes furnished to me by The Diabetic Shoppe and assign my rights to benefits from such insurers to The Diabetic Shoppe, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services.

Pt's Delivery Address:______________________________

Emer Contact Name:____________________ **Emer Ph#:** (   )__________

Please print your name:______________________________

Month/Day/Year

The DiABETiC Shoppe
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Accredited by JCAHO