Quick Start Program

CMN Order
Fax: 866-213-4464
Questions Please Call: 888.958.2960
Full Assignment Accepted

Patient Name:____ Date:________________

Name of Clinic:___________________________________ City: ________________ Phone:________________

In order for Sound Health to process your/a patient's order, we need the following documentation faxed:
*Copy of the **PATIENT FACE SHEET** *signed (**AOB**) (at bottom) ***ORDER SIGNED BY PHYSICIAN**

OSTOMY SUPPLIES

QTY	Item	Product	Allowable	Use
		Drainable Pouches	20 Per Month	1 Every 1 to 2 Days for 12 Months
		Closed Pouches	60 Per Month	2 Per Day for 12 Months
		Barriers	20 EA	Every Barrier Change for 12 Months
		Paste (per ounce)	4oz	Every Barrier Change for 12 Months
		Adhesive Remover (wipe 50bx)	3 Every 6 Months	Every Barrier Change for 12 Months
		Ostomy Belt	1 Per Month	1 Every 30 Days
		Ostomy Deodorant	8oz	Every Time Pouch is Emptied for 12 Months
		Inserts	10 Per Month	1 Every 30 Days
		Tape	2; 1" rolls	1 Every 3 Days for 12 Months
		Skin Prep Wipes	50 Every 2 Months	Every Time Barrier is Applied for12 Months
		Night Bags	2 Per Month	1 Every 2 Weeks for 12 Months
		Leg Bags	2 Per Month	1 Every 2 Weeks for 12 Months

Patient has been trained on how to use product:
___Yes ___No

Prognosis:	
Diagnosis:	
Length of Need:	

Physician's Name:_________________________________ Fax: ______________________ Phone: ______________

Signature: ___________________________ Date: ______________ UPIN: ______________ NPI: _______________

City: ____ State: ___________________________

Assignment of Benefits (AOB)

I request that payment of my insurance benefits be made to Sound Health Medical Supply for any supplies or services furnished to be by Sound Health Medical Supply. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home, opened or unopened, cannot be returned. I authorize any holder of medical information about me to release to Sound Health Medical Supply any information needed to determine benefits payable for these supplies or services. Further, I authorize Sound Health Medical Supply to forward my medical records to the medical professionals in my care and/or make copies of said records.

Please Print

Patient's Name: ________________________ Date of Birth: ___________ Social Security No: _____________________

Address: ____ Phone: ___________________________

Patient's Signature: _____________________ Authorized Signature: ______________________ Date: ______________

Name of Authorized Representative; (LPN): ____

(*If Patient is Unable to Sign*)