AT LAST...
BRA & LINGERIE LLC
atlastbras.com

Customer Information Insurance Verification Form

Referred By:

Last Name:	First Name:	Initial:_____	DOB:
Address:			
City:	State:	Zip Code:	
Email Address:	☐ Please add my name to your mailing list *		
Home Phone: _____	Alternate Phone: _____		
You may leave phone messages for me @			
PHYSICIAN:_____	NPI NUMBER: _____		
Phone: _____	Fax:		
MEDICARE ONLY:			
City: _____	State: _____	IN PECOS? ___ YES	
PRIMARY INSURANCE:	Phone Number:		
Member ID#: _____	Group#:_____		
Policy Holder:	☐ Self	Other:	
SECONDARY INSURANCE:	Phone Number:		
Member ID#: _____	Group#:_____		
Policy Holder:	☐ Self	Other:	
DATE OF SURGERY: ____/____/	SURGERY SIDE:_____Left _____Right		
☐ Lumpectomy	☐ Mastectomy	☐ Any Lymph Node Removal	
☐ Reduction	☐ Reconstruction	☐ Other _____	
☐ Chemotherapy	☐ Radiation Therapy		
Any Further Breast Surgery Type:	Date: _____	Prognosis:	

I HAVE RECEIVED A COPY OF AT LAST… HIPAA PRIVACY NOTICE	Initials
I WILL BE FINANCIALLY RESPONSIBLE FOR ALL PURCHASES, CO-PAYS AND UPGRADES THAT ARE NOT COVERED BY MY INSURANCE.	Initials
I HAVE RECEIVED PRODUCT WARRANTY, CARE AND STORAGE (if applicable)	Initials
I HAVE RECEIVED A COPY OF MEDICARE PROTOCOL/RESOLVING COMPLAINT FORM (if applicable)	Initials
UPON REQUEST, I CAN OBTAIN A COPY OF THE MEDICARE SUPPLIER STANDARDS (if applicable)	Initials
48 HRS RETURN POLICY ON BRAS & PROSTHESIS	Initials

I UNDERSTAND THAT AT LAST… IS A SPECIALTY RETAIL BOUTIQUE / STORE. INFORMATION GIVEN IS TO SUPPORT MAKING LINGERIE DECISIONS AND IS IN NO WAY INTENDED TO REPLACE MEDICAL ADVICE FROM MY PERSONAL HEALTHCARE PROVIDERS. AT LAST… MAKES NO CLAIM OR WARRANTY, OTHER THAN MANUFACTURER'S GUARANTEE OF WORKMANSHIP.

AT LAST… WILL BILL MY PRIMARY INSURANCE CARRIER AS A COURTESY. I WILL BE RESPONSIBLE FOR CO -INSURANCE, CO - PAYMENTS, UPGRADES AND DEDUCTIBLES. I MAY EVEN BE RESPONSIBLE FOR THE ENTIRE PURCHASE IF MY CARRIER DENIES THE CLAIM OR MY COVERAGE IS IN QUESTION. I UNDERSTAND THAT ANY AND ALL BALANCES OWING TO AT LAST… AFTER PAYMENT BY MY PRIMARY INSURANCE CARRIER, IS DUE THIRTY (30) DAYS AFTER BILLING DATE AND AGREE TO PAY A SERVICE CHARGE OF 1-1/2 % ON ACCOUNT BALANCES FOR MORE THAN THE ABOVE - MENTIONED THIRTY (30). IF THE DELINQUENT ACCOUNT IS PLACED IN THE HANDS OF A COLLECTION AGENCY, I FURTHER AGREE TO PAY THE COLLECTION AGENCY FEE NOT EXCEEDING THIRTY PERCENT (30%).

I REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO INTIMATE IMAGE FOR SERVICES RENDERED BY THIS PROVIDER. I AUTHORIZE ANY MEDICAL INFORMATION CONCERNING ME TO BE RELEASED TO ATLAST…, OR TO THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

DATE: SIGNATURE OF BENEFICIARY /PATIENT:

9/9/2017