FAX TO:
(859) 254-6666
ATTN:
BRENDA HAINES

Grogan's
HEALTHCARE SUPPLY

SINCE 1960
- MEDICAL
- SURGICAL
- LABORATORY
- RESPIRATORY
- HOME HEALTH CARE

FAX BACK TO:
_____
ATTN:
_____

PLEASE COMPLETE ALL FIELDS	
Patient Name	
Patient Address	
Patient Phone	
Patient DOB	
Baby DOB	
Physician Name	
Diagnosis Code	V24.1
Insurance Provider	
Provider Phone #	
ID #	
Group#	

For Grogan's Use	
Date Called	
Name of C/S Rep	
Auth Required?	
Rx/Letter of Need/CMN?	
Reference #	
Approved by Grogan's	Yes No

Assignment of Benefits/Authorization for Payment: For any claim which Grogan's Inc. has agreed to accept assignment with my insurance, I hereby assign all benefits and payments to be made directly to Grogan's Inc. for any home medical equipment, supplies, and services furnished to me. For any claim, assigned or unassigned, I authorize Grogan's Inc. to seek such benefits and payments on my behalf.

Release of Information: I hereby request and authorize Grogan's Inc., the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to Grogan's Inc., any payer source, physician, or any other medical personnel or agency involved with service. I also authorize Grogan's Inc. to review medical history and payer information for the purpose of providing home health care.

_____ _____
Patient Signature Date

1016 SOUTH BROADWAY • LEXINGTON, KY 40504
(859) 254-6661 • WATS (800) 365-1020 • FAX (859) 254-6666
www.grogans.com