

MEDPOINT ADVANTAGE

THE ADVANTAGE IS YOURS

COMPLETE THE ENTIRE ENROLLMENT FORM

866-5MEDPOINT

DIABETES PLAN INDIVIDUAL

ENROLLMENT FORM

LAST NAME: _____ FIRST NAME: _____ MI: _____

BIRTH DATE: _____ M F HOME PHONE: _____

RESIDENCE STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NAME AS IT IS LISTED ON YOUR MEDICARE CARD: _____

MEDICARE CLAIM NUMBER _____ - _____ - _____

EFFECTIVE DATE HOSPITAL (PART A) _____

EFFECTIVE DATE MEDICAL (PART B) _____

MEDICAID CLAIM NUMBER _____

INDIVIDUAL OR GROUP INSURANCE COMPANY / PLAN OR MEDICARE ADVANTAGE COMPANY / PLAN INFORMATION: (IF APPLICABLE)

INSURANCE COMPANY / PLAN CARRIER: _____

INSURANCE / PLAN CUSTOMER ID NUMBER: _____

TELEPHONE NUMBER FOR PROVIDERS TO VERIFY BENEFITS OR COVERAGE: _____

PRIMARY DIABETIC PHYSICIAN: _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

DATE OF LAST VISIT: _____ FAX: _____

ARE YOU INSULIN DEPENDENT? YES NO DO YOU USE BYETTA? YES NO

IF YES, DO YOU INJECT IN _____ A.M. _____ P.M. DO YOU USE A: SHORT NEEDLE LONG NEEDLE

HOW MANY TIMES DAILY DO YOU CHECK YOUR BLOOD SUGAR? _____ TIMES DAILY (MINIMUM ONCE DAILY)

DO YOU HAVE A MONITOR? YES NO IF YES, WHAT BRAND MONITOR? _____

CURRENT DIABETIC SUPPLIER: _____ DATE LAST RECEIVED SUPPLIES: _____

I authorize the release of any medical or other information necessary for MedPoint to process and submit my claims. I authorize payments for medical supplies furnished to me by MedPoint be paid directly to them.

I agree that if any insurance company sends me the payments, I will send all of the payments received directly to MedPoint as soon as I receive them. I understand my insurance payments for the supplies belong to MedPoint. I understand that using the insurance payments for anything other than paying for my supplies is against the law.

I authorize MedPoint to contact me at periodic intervals to determine my need for supplies which may be rented or purchased by me.

YOUR SIGNATURE: _____ TODAYS DATE: _____

CITY: _____ STATE: _____ ZIP: _____

PLAN AGENT/PRODUCER SECTION ONLY

AGENT/PRODUCER SIGNATURE: _____  _____ TODAYS DATE: _____

AGENT/PRODUCER: Complete Solutions, Inc AGENT/PRODUCER ID#: 0005-050-624

SUBMIT BY FAX: 866.503.1278

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