

Office use only:  
SR: \_\_\_\_\_



## Script Order Form

Phone: (757) 877-8899 Fax: (757) 877-8870

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

In order for Soluble Systems, LLC to process your patient's order, we need the following documentation faxed:

**\*Copy of the Patient Fact Sheet \* Signed (AOB) (at Bottom) \* Order Form signed by Physician**

	<b>TheraGauze™ - Small</b> <b>2" x 2"</b>	<b>TheraGauze™ - Large</b> <b>4.125" x 4.125"</b>
<b>Quantity Request</b> Please Note: 10 sheets per box. Orders must be in full box quantities.		
<b>Frequency of Change</b>		

Physician's Name: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_

### DRG/ICD-9 CODES (Required for Billing)

Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Assignment of Benefits (AOB)

I request that payment of my insurance benefits be made to Soluble Systems, LLC, for any supplies or services furnished to me by Soluble Systems, LLC. **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 Soluble Systems, LLC, any information needed to determine benefits payable for these supplies or services. Further, I authorize Soluble Systems, LLC, to forward my medical records to 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: (\_\_\_\_) \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

ID#: \_\_\_\_\_

ID#: \_\_\_\_\_

RxBIN#: \_\_\_\_\_

RxBIN#: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

Name of Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

(If patient is unable to sign)