Comfort® Medical

Customer Account Form

If your information has changed since our last discussion, please complete the appropriate section(s) below then:

1. **Print your name and sign the bottom of this page.**
2. **Return this form to us in the enclosed pre-paid envelope.**

1-800-700-4246

Customer Information

Name: ____________________

Phone: ____________________

Email Address: ____________________

Physician Information

Physician Name: ____________________

Phone: ____________________

Primary Insurance Information

Primary Insurance: ____________________

Phone: ____________________

Policy Number: ____________________

Secondary Insurance Information

Secondary Insurance: ____________________

Phone: ____________________

Policy Number: ____________________

By signing below, I acknowledge the following:

- I understand that I can use only one provider for this product category of medical supplies and I have chosen Comfort Medical as my sole provider for this product category. I will inform Comfort Medical immediately if I begin home health services.
- In accordance with its Notice of Privacy Practices, Comfort Medical may obtain medical information necessary in order to process my order, determine eligibility, and seek reimbursement for medical supplies provided to me by Comfort and contact me or my designees to discuss my medical supplies. Comfort Medical may release my medical information to and directly bill Medicare, Medicaid, and/or other insurer(s) and their agents on my behalf for medical supplies provided to me by Comfort.
- I have received the Comfort Welcome Kit, which includes the Customer Rights and Responsibilities, the Notice of Privacy Practices, the location reference of the CMS Supplier Standards, and all other required regulatory notifications. I have read and understand its content.

Please print your name ____________________

Signature **Date**

SIGN HERE **DATE HERE**