



# Independent Living Aids of Georgia

6002 Veterans Parkway, Columbus, GA 31909  
(706) 327-5613 (888) 203-6114  
Fax: (706) 327-2099

NEW SET-UP: \_\_\_ ADD-ON: \_\_\_ SUPPLY: \_\_\_

MOBILITY CONSULTANT Robin Grantham

NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

LEGAL RESIDENCE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SEX:  Male  Female HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

PRIMARY INSURANCE CARRIER: \_\_\_\_\_ ID#: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_ ID#: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ UPIN #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE LAST SEEN: \_\_\_/\_\_\_/\_\_\_

**CHECK BOX IF APPLICABLE**

1.  Do you treat this patient for diabetes?
2.  Does the patient have insulin treated diabetes? (Code 250.01) Other: \_\_\_\_\_
3.  Does the patient have non-insulin treated diabetes? (Code 250.00)
4.  Is the patient or care giver capable of learning proper operation of the monitor?
5.  Is the monitor designed for 'home use' rather than 'clinic use'?
6.  Is the patient capable of using the results for proper glycemic control?
7. \_\_\_ Approximately how many times per day is the patient instructed to check blood sugar? (Enter the number of times per day)

PHYSICIAN SIGNATURE: X \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

Qty	Equipment # (Office Only)	EQUIPMENT DESCRIPTION	HCPCS CODE (Office Only)	TRANS TYPE (Office Only)	SERIAL # (Office Only)

**AUTHORIZATION**

"I request that the payment of all authorized insurance benefits be made on my behalf to *Independent Living Aids of Georgia* for any services furnished to me by that provider for a lifetime. I authorize any holder of medical information about me to release to *Independent Living Aids of Georgia*, and its agents, any information needed to determine these benefits or the benefits payable for related services.

**AGREEMENT OF RECIPIENT RESPONSIBILITY - (Please Read & Sign)**

1. I agree to pay *Independent Living Aids of Georgia* for all amounts due, INCLUDING ANNUAL DEDUCTIBLE, for purchases not covered by my insurance carrier. 2. I accept responsibility for damage to the equipment in event of fire, loss, abuse, or other than normal wear. 3. I will notify *Independent Living Aids of Georgia* of any change of address. 4. I agree to reimburse *Independent Living Aids of Georgia* any payments made to me for the purchase of my equipment. (SIGNATURE BELOW)

**AUTHORIZATION TO SEND MONTHLY SUPPLIES**

I give *Independent Living Aids of Georgia* or its affiliates authorization to send blood glucose supplies prescribed by my physician as needed according to physician orders. Syringes and/or alcohol pads will be included whenever covered by the insurance carrier. I understand my insurance company will be billed for these supplies. If my needs should change, I will contact *Independent Living Aids of Georgia* at (706) 327-5613 or (888) 203-6114.

- PLEASE SEND BLOOD GLUCOSE SUPPLIES AS PRESCRIBED BY MY DOCTOR  
 I DO NOT WANT INDEPENDENT LIVING AIDS OF GEORGIA TO SEND BLOOD GLUCOSE SUPPLIES AS PRESCRIBED BY MY DOCTOR.

PATIENT / CARE GIVER: X \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_