PLEASE DO NOT WRITE IN MARGINS

ORDER FORM

CUSTOM PRESSURE GARMENTS

SUBMIT THIS FORM WITH ALL ORDERS, REORDERS & ALTERATIONS

Bio Concepts compression garments

2424 East University Drive, Phoenix, Arizona, U.S.A. 85034-6911
VOICE: 800-421-5647 / 602-267-7854 • FAX: 800-650-9424 / 602-273-6931
e-mail:bio-con@bio-con.com • worldwideweb:http://www.bio-con.com

Bio-Concepts Patient Number **PAT_____**

☐ New Patient ☐ Existing Patient

ORDER DATE _____ MM/DD/YYYY

NEED BY DATE _____ MM/DD/YYYY

SHIP TO ☐ Facility ☐ Patient

Specify Shipping Method: _____

REQUIRED PATIENT INFORMATION

Date of Birth _____ MM/DD/YYYY **Gender** _____

NOTE: **Bio-Concepts Custom Pressure Garments are available only under physician's orders.**

Last Name _____ **First Name** _____

IS THIS A BURN PATIENT? ☐ Yes ☐ No ☐ Edema ☐ Traumatic Scar ☐ Lymphedema

Desired Pressure: _____ mmHg Other: _____

FACILITY INFORMATION

Purchase Order # _____

Billing Contact _____

Billing Telephone _____

Measured by _____

Quickest way to contact you: Telephone/Pager/Fax/Email

Name of Facility _____

Shipping Address

The full destination address. Include the department, room number, apartment number, etc. If shipping to patient, include the patient's phone number.

Billing Address

The address where we will send our invoice if different from the shipping address. If we are to bill insurance, write "insurance" and provide information below.

IF BILLING INSURANCE/WORKMAN'S COMP/HEALTH PLAN

NOTE: Please leave these spaces blank unless you want us to try billing the patient's health plan. Attach a copy of the prescription, letter of medical necessity, insurance card, and, if available, a copy of the hospital face sheet.

Insurance Carrier _____

Date of Injury _____ MM/DD/YYYY

Insurance Telephone _____

Garment(s) Ordered

Part No.	Description	Qty L	Qty R	Total Qty

NEVER RESEND OLD CHARTS OR OLD MEASUREMENTS TO REORDER

BIO-CONCEPTS USE ONLY

(Please write nothing in this block)

Download these charts at: www.bio-con.com/custom_garments.php

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