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: _____ **AGENT/PRODUCER ID#:** _____

SUBMIT BY FAX: 866.503.1278

WEBSITE: www.medpointadvantage.com
E-MAIL: mail@medpointadvantage.com

MAIL: POST OFFICE BOX 11574
BIRMINGHAM, ALABAMA
35202