Western Medical Equipment, LLC

180 North Center St. #5 Jackson, Wyoming 83001
Tel: 307-200-6222 Fax: 877-468-1214

Name: ______________________________________ Tel: ________________________ D.O.B.:______________

Address: ____

Insurance ID #: _______________________________ Name of Primary Insured: _______________________

Group #: ______________________________ Insurance Company Name: __________________________

Western Medical Equipment, (WME), is in network and will bill, BCBS, insurance companies and First Choice of the Midwest PPO.

As an in-network provider, we accept the determination from these companies. In the event of a denial of coverage, or if you have not met your deductible, you are responsible for the amount of the product provided as stated below.

No insurance company guarantees coverage, even with a pre-authorization or pre-certification.

Returns: This product is a personal use item and not eligible for return under any circumstance. If you believe it has a defect, please contact us and we will contact the manufacturer for a possible exchange or replacement.

Limitation of Liability and Indemnity Limitation of liability - In no event will WME be liable to the Customer for any Incident, indirect or consequential damages however caused, whether by WME's negligence or otherwise. Indemnity - The Customer agrees to protect, indemnify and hold harmless WME from and against all claims, damages and costs including legal expenses arising out of the Customer's use of this Equipment.

I authorize my physician to release to Western Medical Equipment, (WME), and for WME to release to my insurer any needed information for this or a related claim. I request that Payment of authorized benefits be made on my behalf, and I assign the benefits payable for the medical equipment provided by WME to WME. Although I recognize that I have the primary responsibility for contacting and submitting claims to my insurer,

I have received the equipment and authorize WME to submit a claim to any of the insurers as may be required. I understand that I am responsible for deductibles and co-payments not covered by my insurance. **Should my insurance plan not provide coverage in its entirety for any reason, I understand that I will be responsible for payment.**

I recognize there are a number of medical providers to choose from and I am selecting to WME to provide my equipment.
I understand that Medicare will only cover CPM treatment for total knee replacement.

Patient Signature: ____ Date: _________________

Your signature on this form indicates that you have received the prescribed product.