ARMAC

BRACEREQUEST

Patient Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ ☐ H ☐ W ☐ C Secondary Phone #: _____ ☐ H ☐ W ☐ C

Email Address: _____ @ _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Primary Subscriber: _____ Date of Birth: _____ Relationship: _____

Insurance Address: _____ Phone #: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Secondary Subscriber: _____ Date of Birth: _____ Relationship: _____

Insurance Address: _____ Phone #: _____

Tertiary Insurance: _____ Policy #: _____ Group #: _____

Tertiary Subscriber: _____ Date of Birth: _____ Relationship: _____

Insurance Address: _____ Phone #: _____

Nature of your injury: ☐ Workers Comp ☐ Automobile ☐ Other Date of Injury: _____

Insurance / Adjuster / Attorney Information: _____

_____ Claim #: _____

Diagnosis Code or Description (from your physician): _____

Prescribing Doctors: _____ Phone #: _____

Product / Description: _____ ☐ Right ☐ Left ☐ Both

Have you received products from ARMAC in the past ☐ Yes ☐ No

I authorize my physician to release to ARMAC Inc, and for ARMAC Inc to release to my insurer, any needed information to this or a related claim.

Patient / Guardian Signature: _____ Date: _____

Contact Name: _____ Date of fax: _____

Please fax this form and a copy of the prescription from your physician to 973-328-3753. Give us a call if you have any quesitons.

EMAIL *send directly to us* PRINT *fax or deliver to us*