

ORDER FORM
CUSTOM PRESSURE GARMENTS

SUBMIT THIS FORM WITH ALL ORDERS, REORDERS & ALTERATIONS



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

NEED BY DATE

SHIP TO Facility
 Patient

Specify Shipping Method:

MM/DD/YYYY

MM/DD/YYYY

Garment(s) Ordered

Part No.

Description

Qty L

Qty R

Total Qty

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 # _____

Measured by _____

Billing Contact _____

Billing Telephone _____

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

Name of Facility _____

Shipping Address

Billing Address

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

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 _____

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