



SFO Medical Supply Inc
1400 Coleman Ave Ste G16
Santa Clara CA 95050
Ph. 408-562-0058 Fax 408-404-6266
<http://www.sfomedical.com>

Insurance claims procedure

Please submit following for SFO Medical to process claim

- ◆ Complete copy of insurance form
- ◆ Signed copy of insurance policies form
- ◆ Copy of Prescription (or letter of medical need with diagnostic code)
- ◆ Copy of back and front of your insurance card

Submit completed docs to insurance@sfomedical.com or fax to 408-404-6266



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Insurance Claims From

Product Description			
Product Name	Model No.	Quantity	Description

Beneficiary Information

Name			
Street Address			
City, Zip, State			
Phone			
Date of Birth			
Gender	Male/Female		

Name of legally responsible representative (if different from beneficiary)

Name			
Street Address			
City, Zip, State			
Phone			
Date of Birth			
Gender	Male/Female		
Relationship to beneficiary			

Insurance information

Primary Insurance company	
Insurance Company Name	
Group No.	
ID No.	
Insurance company phone	
Secondary Insurance, if any	
Insurance Company Name	
Group No.	
ID No.	
Insurance company phone	

I certify that above information is correct and I authorize SFO Medical Supplies Inc to file insurance claim with my insurance company for the above mentioned DME product.

Sign here

Date

Required documents

- ◆ Prescription or letter of medical need from physician with diagnostic code
- ◆ Copy of Front and back of insurance card



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Agreement to Insurance Policies

Please submit following for SFO Medical to process claim

- ◆ All documents are required to be submitted with full and correct information before claim can be processed
- ◆ Doctor's prescription or letter of medical need from treating physician must be submitted with diagnosis code
- ◆ Customer is responsible for his or her portion of co-payment
- ◆ Full Payment must be received before product can be shipped
- ◆ Upon full payment by insurance, the product will be shipped.
- ◆ Customer can prepay full cost of the product and SFO will reimburse upon receipt of payment from insurance company

I certify that I have read the above information and agree to terms set there and policies

Sign here

Date