Doctor Order Form

Boutique Order Form

Instructions: Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to BLN. If you have any changes, please cross out; write in correction, sign, and date.

185 Oser Ave.
Hauppauge, NY 11788
Call: 1.800.854.5729
Fax: 1.877.262.2183
www.BetterLivingNow.com

Referral

Order Date:	Ordered By: Referral Source	Phone#:	Referral Source #: - BLN Use Only -	Referral Type #: - BLN Use Only -	BLN Processor: - BLN Use Only -

Patient Info

BLN Account Number: BLN Account #	Patient's Primary Insured ID#: Patient's ID# 1	Patient's Secondary Insured ID#: Patient's ID# 2	Sex: M F	Date of Birth: /DOB/

Patient's Last Name: Patient's Last Name	Patient's First Name: Patient's First Name	Middle Initial:	Relationship to Member: M / S / C / O	Daytime Phone Number:

Address 1:	Apt#:	City:	State:	Zip Code:	Nighttime Phone Number:

Member

Member's Primary Insured ID#: Member's ID#	Member's Last Name: Last Name	Member's First Name: First Name	Middle Initial:	Date of Birth:	Sex: (Circle) M F	Daytime Phone Number:

Address 1:	Apt#:	City:	State:	Zip Code:	Nighttime Phone Number:

Primary Insurance

Primary Insurance:	Policy / Group # :
Primary Insurance Address:	Insurance Type: o Medicare o Indemnity o HMO o PPO
	Primary Insurance Phone #:
City:	State: Zip Code:
BLN Payer #:	Authorization#: Pre- Authorization / Contact:

Secondary / Supplemental Insurance

Secondary Insurance:	Policy / Group #:
ID Number for Secondary Policy :	Secondary Insurance Type: o Medicare o Indemnity o HMO o PPO
Secondary Insurance Address:	Secondary Insurance Phone #:
City:	State: Zip Code:
BLN Payer #:	Authorization#: Pre- Authorization / Contact:

Payment Info

Cash

o COD o Check or Money Order payable to **Better Living Now, Inc.**

Charge to Credit Card:

o MasterCard o Visa o Discover o American Express

. / / / .

Card Expiration Date: /

Cardholder Signature: Cardholder Signature

Cardholder Name as on Card:

Diagnosis

Check Appropriate Diagnosis:

o 457.0 POSTMASTECTOMY LYMPHEDEMA o 459.81 VASCULAR DISEASE o 250.02 DM II WO CMP UNCNTRLD

o 457.1 LYMPHEDEMA SYNDROME o 757.0 OTHER LYMPHEDEMA o 457.9 VARICOSE VEINS

o 174.1 BREAST CA CENTRAL PORTION o 174.0 BREAST CA NIPPLE AND AREOLA o 174.9 BREAST CA FEMALE NOS

o **233.0 CA IN SITU BREAST** o **Other:**

Check √	Please Circle Desired Item Below	Order Number	Quantity
	Prosthetic — **Please provide order number**		
	Bras — **Please provide order number**		
	Stockings **Type:** Full Knee high Thigh High — **Please provide order number**		
	Lymphodema Sleeves Lymphodema Glove — **Please provide order number**		
	Turbans — **Please provide order number**		
	Bathing Suit — **Please provide order number**		
	Other: — **Please provide order number**		
	Other: — **Please provide order number**		

Doctor's Information

Dr.'s Stamp:	THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX BELOW ☐ Dispense As Written	
Dr's Name:		
Dr's Address:		
Dr's City: State: Zip Code:	Dr's Signature:	Date of Visit::
Dr's Phone#: Dr's UPIN#:	Dr's License#:	Dr's DEA#:

DI0303

*****Please see other side for additional instructions*****

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Boutique Order Form

Instructions

a) Patient

i) Please complete the Member section of the order form on the reverse side indicating the insurance you have that provides coverage for your Urological Supplies.

b) Doctor/Authorized Healthcare Provider

i) Please complete the patient information and doctor information sections.

ii) Please indicate the products you want supplied to the patient, with directions for use and quantity required;

iii) Please sign and date on the spaces provided.