



Compassion\*Works Medical, LLC.  
 Medical Reimbursement Specialists  
 11 Rande Dr., Wayne, NJ 07470  
 Tel: (973) 832-4736, Fax: (973) 387-1223  
 Email: support@compassionworksmrs.com

## Coverage Assistance Form

PATIENT INFORMATION			
<u>LAST NAME</u>	<u>MIDDLE INITIAL</u>	<u>FIRST NAME</u>	
<u>DATE OF BIRTH</u> / /	<u>AGE</u>	<u>SS # (Optional)</u>	<u>GENDER</u> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<u>STREET ADDRESS</u>	<u>APT#</u>	<u>CITY</u>	<u>STATE</u> <u>ZIP</u>
<u>EMAIL ADDRESS</u>	<u>EMPLOYMENT STATUS</u> <input type="checkbox"/> CHILD <input type="checkbox"/> EMPLOYED F/T <input type="checkbox"/> EMPLOYED P/T <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> DISABLED <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> STUDENT <input type="checkbox"/> OTHER		
<u>PHONE</u>	<u>WORK NUMBER</u>	<u>OTHER PHONE</u>	
GENETIC DISORDER			
<u>DISORDER</u>	<u>CURRENT MEDICAL FOOD</u>	<u>AMOUNT PER DAY</u>	<u>CURRENT DME/PHARM</u>
CLINIC INFORMATION			
<u>DIETITIAN/PHYSICIAN</u>	<u>CLINIC</u>	<u>PHONE #</u>	<u>FAX #</u>
RESPONSIBLE PARTY / PARENT / CAREGIVER (GUARANTOR) INFORMATION			
<b>RELATIONSHIP TO PATIENT:</b> <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER _____			
<u>LAST NAME</u>	<u>FIRST NAME</u>	<u>MIDDLE INITIAL</u>	<u>PHONE NUMBER #</u>
PRIMARY INSURANCE INFORMATION			
<u>INSURANCE NAME</u>	<u>PHONE NUMBER</u>	<u>MEMBER ID #</u>	<u>GROUP #</u>
<u>MEMBER NAME</u>	<u>MEMBERS DATE OF BIRTH</u>	<u>RELATIONSHIP TO MEMBER</u>	
SECONDARY INSURANCE INFORMATION			
<u>INSURANCE NAME</u>	<u>PHONE NUMBER</u>	<u>MEMBER ID #</u>	<u>GROUP #</u>

**Authorization for Release of Health Information:** I HEREBY AUTHORIZE RELEASE OF HEALTHCARE INFORMATION. This information contained herein may be shared to Compassion\*Works Medical, LLC and its affiliates for quality purposes to ensure that the necessary resources are available to service you for medical food reimbursement support. Such information is furnished in compliance with HIPAA to allow for the best service. I also understand and agree to Compassion Works Medical's Notice of Privacy Practices.. Nonetheless, if you do not wish for this information to be shared with Compassion\*Works Medical call (973) 832-4736 and our HIPAA Privacy Officer will assist you with this request and ensure that the information is not shared.

Signature of applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Representative of applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Representative Title: \_\_\_\_\_