

POS-T-VAC™ MEDICAL
1701 N. 14TH Avenue
Dodge City, KS 67801
Toll Free 1-800-279-7434
Fax 1-620-227-8474
erect@postvac.com

Dear Sir:

I request that payment of authorized insurance benefits, including Medicare, be sent on my behalf to Pos-T-Vac or their agents for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, Medicare, my insurance carrier or other medical entity.

A copy of this authorization will be sent to Medicare, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charge not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. My estimated financial responsibility (co-payment), if deductible has been met, is no more than \$95.00.
(Please send no Money Now!!)

I understand that if Medicare has purchased me a Vacuum Erection Device in the past 5 years I will be responsible for the full balance.

I understand that if I have a financial hardship it is my responsibility to contact Pos-T-Vac prior to delivery of the product to discuss financial arrangements, or to complete paperwork documenting my financial hardship, as required by Medicare, for the waiver of co-payment fees when secondary insurance is not in place.

Signed _____ Date _____

Print Name _____