SMG Mediquip, LLC
P.O. Box 736
Bethpage, NY 11714-0736
Phone: 516.586.4934
Fax: 800-717-2573
Fax: 800-211-0404
www.smgmediquip.net

EXPRESS VERIFICATION FORM

PHYSICIAN:_____ **PHONE:**_____ **DATE:** _____

PATIENT NAME:	**Date of Birth:**
Insurance Company:	**Please Check**: Major Med ___ **Workers Comp ___ No-Fault ___
Insurance Phone #:	**Insurance ID/Claim #:**
Date of Injury/Accident (if applicable):	**Equipment Requested:** Tens___ Cervical Traction Unit___ Lumbar Brace___ Lumbar Traction Unit ___ Other_____

PATIENT NAME:	**Date of Birth:**
Insurance Company:	**Please Check**: Major Med ___ **Workers Comp ___ No-Fault ___
Insurance Phone #:	**Insurance ID/Claim #:**
Date of Injury/Accident (if applicable):	**Equipment Requested:** Tens___ Cervical Traction Unit___ Lumbar Brace___ Lumbar Traction Unit___ Other_____

PATIENT NAME:	**Date of Birth:**
Insurance Company:	**Please Check**: Major Med ___ ** Workers Comp ___ No-Fault ___
Insurance Phone #:	**Insurance ID/Claim #:**
Date of Injury/Accident (if applicable):	**Equipment Requested:** Tens___ Cervical Traction Unit___ Lumbar Brace___ Lumbar Traction Unit___ Other_____

PLEASE FAX YOUR COMPLETED FORM TO 800-211-0404

(**Note: For Workers' Comp patients, attach a completed Prescription Form/Letter of Medical Necessity)

Note: All information provided is confidential and utilized in order to verify coverage and benefits with each patient's insurance company. Information will not be distributed to any other third party provider(s).