

Benefits and Eligibility Sheet for Custom Care Solutions, LLC

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Date: _____

Patient Name: _____ Date of Birth _____

Anticipated Start Date: _____

Therapist w/ credentials: _____

Phone: _____ Fax: _____

Physician: _____

Phone: _____ Fax: _____

Diagnosis: _____

Insurance:

Primary: _____ Secondary: _____

Patient Demographic Insurance Card

Affected Limb / Body Part (Circle): UE R L Head and Neck

LE R L Genitals Other: _____

Bandaging Kit Required (Circle): Arm ½ Leg Full Leg Qty: _____

Other: _____

Garments to be ordered (Anticipated):

Off the Shelf:

- Knee High
- Thigh High
- Pantyhose/Waist High
- Sleeve
- Glove
- Tribute / ready wrap
- CircAid
- Other: _____

Custom:

- Knee High
- Thigh High
- Pantyhose/Waist High, Capri
- Sleeve
- Glove
- Tribute – Ready Wrap
- CircAid
- Other: _____

Has the patient recently been discharged from a Skilled Nursing Facility (SNF)? Yes No
What is the likelihood of the patient being admitted into a SNF in the next 30 days? Yes No