Health First
Medical
EQUIPMENT

129 West Hibiscus Blvd., Suite A
Melbourne, FL 32901
P: 321-434-3400
F: 321-727-1200
Health-First.org/MedicalEquipment
MedicalEquipment@Health-First.org

Please complete form and mail or fax to Medical Equipment. Please type or print all information.

CUSTOMER INFORMATION:

Patient Name: _____ Date: _____
Patient ID: _____
Patient DOB: _____
Billing Address: _____
Delivery Address (If Different than Billing Address): _____
City, State, Zip: _____
Email Address: _____
Phone Number: Day _____
Evening _____

DOCTOR INFORMATION:

Primary Physician: _____
Attending Physician: _____

INSURANCE INFORATION:

Payor 1: _____
Payor 2: _____
Payor 3: _____

PRODUCTS TO ORDER: You must have a current/valid prescription on file with us to use this form.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

PAYMENT INFORMATION:

☐ Use Credit Card on File: ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex

Name on Card: _____ Card Number: _____ Expiration Date: _____

CVV Code: _____ Cardholder Signature: _____

SHIPMENT:

☐ Please ship my supplies ☐ Please call me when my order is ready for pick up

☐ Please keep this credit card on file for future orders. Cardholder must sign the first time.
☐ I understand that I am fully responsible for all amounts not covered by the insurance company.
☐ I have read and accepted the Health First Joint Notice of Privacy Practices (located at www.health-first.org/patients_visitors/nopp_englff001933_june2011.pdf)