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:	Custom:
❑ Knee High	❑ Knee High
❑ Thigh High	❑ Thigh High
❑ Pantyhose/Waist High	❑ Pantyhose/Waist High, Capri
❑ Sleeve	❑ Sleeve
❑ Glove	❑ Glove
❑ Tribute / ready wrap	❑ Tribute – Ready Wrap
❑ CircAid	❑ CircAid
❑ Other: _____________	❑ 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**