



417-887-7525 or 417-269-0650
 Toll Free 1-800-637-9201
 Fax: 417-887-2542 or 417-269-0692
 2220 W. Sunset
 Springfield, MO 65807

Authorization for Treatment and Financial Responsibility

Affiliated with CoxHealth

Client's Last Name:	First Name:	Middle Initial:
_____	_____	_____

I agree, request and authorize **Home Parenteral Services** to administer such treatment as is necessary under the medical supervision and order of _____ MD/DO.

I agree that I am financially responsible for payment of all amounts for services provided by **Home Parenteral Services**. I certify that the information given by me in applying for payment under my insurance company(s) or other responsible parties is correct. I request that payment of authorized benefits be made on my behalf directly to **Home Parenteral Services**. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I also understand that I am financially responsible for non-covered services, deductibles, co-pay, or co-insurance as defined in my policy and plan.

It is the responsibility of the Patient or the Responsible Party to notify **Home Parenteral Services** of any additional benefit coverage or changes in current benefit coverage prior to the effective date(s) of change. **Failure to do so could result in additional charges for the patient or responsible party.**

Insurance	Policy#		
_____	_____		
City	State	Zip	Medicare#
_____	_____	_____	_____
Phone	Medicaid#		
_____	_____		

Patient's Signature	Date
_____	_____
Signature: Legal Guardian or Responsible Party	Date
_____	_____
Signature: Home Parenteral Service's Representative	Date
_____	_____

Benefits quoted **but not guaranteed**. Any description given is not a certification of benefits or a guarantee of payment and is subject to the exclusions, limitations and provisions outlined in your plan brochure. Benefits will be determined at the time the claim is submitted:

ESTIMATED COST/Type of Therapy: _____

ESTIMATED COST to Patient: _____
