CHECK 7

AUTHORIZATION OF PAYMENT AND WARRANTY

GENUINE Dr.Comfort® EST. USA ™

Patient Info

PATIENT NAME	RECORD ID	
PATIENT MCI#		
DELIVER ADDRESS		
CITY	STATE	ZIP CODE

I have received _____(enter "2" for a pair) individual Dr. Comfort®

(Style: _____Color: _____Size: _____Width: _____)

"extra depth" shoes and (choose one below):

☐ _____(enter "6" for 3 pairs) individual Dr. Comfort® full contact custom therapeutic inserts (A5513/A5514 PDAC compliant).

☐ _____(enter "6" for 3 pairs) individual Dr. Comfort® therapeutic inserts (A5512 PDAC compliant).

Authorization

I authorize Medicare and my supplemental insurance to pay _____directly, as I am satisfied with the fit of the shoes and inserts I received. I understand Medicare may reimburse for up to one pair of shoes (2 individual) and 3 pair of inserts (6 individual) per calendar year. I understand that I am responsible for any deductible and unpaid balance that Medicare and/or my co-insurance does not cover. I have not received any other shoes or inserts under this plan from any other supplier in this calendar year.

Patient's Warranty Statement: Our office will accept returns of any Dr. Comfort® shoes, for any reason within thirty days of the shoes being dispensed. If, within thirty days, we determine the shoes do not fit properly, we will replace them at no extra charge with a properly fitted shoe. Dr. Comfort® shoes that have been dispensed for a period of over thirty days will only be exchanged or credited at our discretion. Any shoes that are returned must be returned in the original, unaltered shoe box.

Supplier Standards and Break-in Procedure: The Supplier has provided me with current, written copies of the Medicare DMEPOS Supplier Standards, and Footwear Instructions. The supplier has educated me on the proper break-in procedure for my Dr. Comfort® shoes. The Supplier has also provided me with a "complaint protocol" to resolve any further disputes regarding the products dispensed.

PATIENT SIGNATURE	DATE
WITNESS SIGNATURE	DATE

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