SunMED *Medical Solutions*

SunMEDMedical.com
t: 800-714-7434 » f: 800-715-5422

SunMED Quick Fill Program

Clinic Name: ____________________ Therapist: ____________________ Diagnosis: ____________________

Patient Name: ____________________ Phone: ____________________ Email: ____________________

❑ I want to use my insurance card ❑ I want to use my credit card **Contact our Need it Now Hotline 844-830-3880 or fax to 800-715-5422**

UPPER EXTREMITY

	SLEEVE	GLOVE, GAUNTLET, COMPRESSION BRA	NIGHTTIME GARMENT
Extremity:	❑ Left ❑ Right ❑ Bilateral	❑ Left ❑ Right ❑ Bilateral ❑ Glove ❑ Gauntlet ❑ Bra	❑ Left ❑ Right ❑ Bilateral
Style:	❑ Ready to Wear ❑ Custom	❑ Ready to Wear ❑ Custom	❑ Ready to Wear ❑ Custom
Compression mmHG:	❑ 18-20 ❑ 20-30 ❑ 30-40 ❑ 40-50	❑ 18-20 ❑ 20-30 ❑ 30-40 ❑ 40-50	
Size:	____________	**Size:** ____________	**Size:** ____________
Manufacturer:	❑ Jobst ❑ Juzo ❑ Medi ❑ Sigvaris ❑ LympheDivas ❑ Solidea ❑ Gottfried ❑ KT Medical ❑ Barton-Carey ❑ Solaris	❑ Jobst ❑ Juzo ❑ Medi ❑ Sigvaris ❑ LympheDivas ❑ Gottfried ❑ KT Medical ❑ Barton-Carey ❑ Bellisse ❑ Solaris	❑ Solaris ❑ CircAid ❑ BiaCare ❑ Peninsula ❑ Jovi ❑ Farrow
Style Name:	____________	**Style Name:** ____________	**Style Name:** ____________
Options:	❑ Silicone band ❑ No Silicone band	❑ Silicone band ❑ No Silicone band	
Color:	❑ Black ❑ Beige ❑ Other ____	❑ Black ❑ Beige ❑ Other ____	❑ Black ❑ Beige ❑ Other ____
Quantity:	❑ 1 ❑ 2 ❑ 3 ❑ 4	❑ 1 ❑ 2 ❑ 3 ❑ 4	❑ 1 ❑ 2 ❑ 3 ❑ 4
Donning Aid?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

LOWER EXTREMITY / TRUNK

	LEG GARMENTS	MISCELLANEOUS LEG GARMENTS	NIGHTTIME GARMENT
Extremity:	❑ Left ❑ Right ❑ Bilateral	❑ Left ❑ Right ❑ Bilateral	❑ Left ❑ Right ❑ Bilateral
Item:	❑ Knee High ❑ Thigh High ❑ Pantyhose Option: ❑ Open Toe ❑ Closed Toe	❑ Chaps ❑ Capri ❑ Bike Short ❑ Toe Caps ❑ Truncal ❑ Post Op Boot	❑ Knee High ❑ Thigh High ❑ Pantyhose ❑ Chaps ❑ Capri ❑ Bike Short ❑ Truncal
Style:	❑ Ready to Wear ❑ Custom	❑ Ready to Wear ❑ Custom	❑ Ready to Wear ❑ Custom
Length:	❑ Short ❑ Regular ❑ Long		❑ Short ❑ Regular ❑ Long
Compression mmHG:	❑ 18-20 ❑ 20-30 ❑ 30-40 ❑ 40-50	❑ 18-20 ❑ 20-30 ❑ 30-40 ❑ 40-50	
Size:	____________	**Size:** ____________	**Size:** ____________
Manufacturer:	❑ Jobst ❑ Juzo ❑ Medi ❑ Sigvaris ❑ LympheDivas ❑ Solidea ❑ Gottfried ❑ KT Medical ❑ Barton-Carey ❑ Solaris	❑ Jobst ❑ Juzo ❑ Medi ❑ Sigvaris ❑ LympheDivas ❑ Gottfried ❑ KT Medical ❑ Barton-Carey ❑ Solaris	❑ Solaris ❑ CircAid ❑ BiaCare ❑ Peninsula ❑ Jovi ❑ Farrow
Style Name:	____________	**Style Name:** ____________	**Style Name:** ____________
Options:	❑ Silicone band ❑ No Silicone band	❑ Silicone band ❑ No Silicone band	
Color:	❑ Black ❑ Beige ❑ Other ____	❑ Black ❑ Beige ❑ Other ____	❑ Black ❑ Beige ❑ Other ____
Quantity:	❑ 1 ❑ 2 ❑ 3 ❑ 4	❑ 1 ❑ 2 ❑ 3 ❑ 4	❑ 1 ❑ 2 ❑ 3 ❑ 4
Donning Aid?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Call or Fax us for Insurance Benefit Verification or Low Self-Pay Pricing

t: 800-714-7434
f: 800-715-5422

Physician's Signature: ____________________ Date: __________ Phone: ____________

Name: ____________________ City: ____________________ State: ______

Effective 4/24/2015. All prices subject to change without notice.