

INSURANCE & FSA SUBMISSION FORM

Contact your insurance company directly about submitting a claim for reimbursement.
You may need to get pre-approval for certain plans.

PATIENT OR CLIENT INFORMATION

First Name _____ Last Name _____ DOB ____/____/____
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Home Phone () _____ Cell () _____ Email _____

INSURANCE HEALTH PLAN

Insurance Co. _____ Subscriber _____ DOB ____/____/____
Policy # _____ Group / Plan # _____
Insurance Co. Phone () _____ PPO HMO Co-Pay % _____

Patient / Client Signature _____ Date _____

PRESCRIPTION INFORMATION & ICD-10 CODES

- | | | |
|--|---|--|
| <input type="checkbox"/> Back Pain M54.5 | <input type="checkbox"/> Sciatic Pain M54.30 | <input type="checkbox"/> Pelvic Joint Pain M25.559 |
| <input type="checkbox"/> Posture M54.89 | <input type="checkbox"/> Swelling/Edema R60.0 | <input type="checkbox"/> Post-Op Pain G89.18 |
| <input type="checkbox"/> Rectus Diastasis M62.00 | <input type="checkbox"/> Pelvic Girdle Pain R10.2 | <input type="checkbox"/> Perineum Pain R10.2 |
| <input type="checkbox"/> Pubic Symphysis 071.6 | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Gestational Weeks _____ |
| <input type="checkbox"/> Hemorrhoids K64.4 | | |

PRODUCT SELECTION & CPT CODES

- Upsie Belly CPT CODE: _____ 2-in-1 Bandit CPT CODE: _____
 Belly Wrap CPT CODE: _____ C-Section Undies CPT CODE: _____

Please make sure to check for possible reimbursement under your Flexible Spending Account.
This form is only applicable for customers in the United States.

For all questions please contact your insurance provider directly.