COMFORTCARE HOME MEDICAL

comcare.store | Sandy Springs, GA

Insurance Reimbursement Request Form

Please complete all sections of this form and submit it along with the required documentation to your insurance provider for reimbursement consideration.

SECTION 1: PATIENT INFORMATION

Patient Full Name:	
Date of Birth:	
Address:	
City / State / ZIP:	
Phone Number:	
Email Address:	

SECTION 2: INSURANCE INFORMATION

Insurance Company Name:	
Policy Number:	
Group Number:	
Policyholder Name (if different):	
Policyholder Relationship to Patient:	
Claims Mailing Address / Portal:	

SECTION 3: PRESCRIBING PHYSICIAN INFORMATION

Physician Name:	
Physician Phone:	
Physician Fax:	
Diagnosis / Medical Necessity:	
Prescription Date:	

SECTION 4: EQUIPMENT RENTAL DETAILS

Item Description	HCPCS Code (if known)	Rental Start Date	Rental End Date	Monthly Rate	Total Charged
TOTAL AMOUNT PAID:	**$**				

SECTION 5: PAYMENT INFORMATION

Payment Method: ☐ Credit Card ☐ Debit Card ☐ Cash ☐ Check ☐ Other:

Payment Date(s):	
Receipt / Invoice Number(s):	
Total Amount Paid:	**$**

SECTION 6: PROOF OF PAYMENT & SUPPORTING DOCUMENTS

Please check all documents included with this submission:

☐ Itemized receipt(s) from ComfortCare Home Medical

☐ Physician's prescription or letter of medical necessity

☐ Copy of insurance card (front and back)

☐ Rental agreement from ComfortCare Home Medical

☐ Proof of payment (credit card statement, bank statement, or cancelled check)

☐ HCPCS/CPT codes for equipment (if available)

☐ Other supporting documentation:

SECTION 7: PATIENT CERTIFICATION & SIGNATURE

I certify that the information provided on this form is true and accurate to the best of my knowledge. I understand that submitting false or misleading information may result in denial of my claim. I authorize ComfortCare Home Medical to release any necessary records to my insurance company for the purpose of processing this reimbursement request.

Patient Signature:	
Printed Name:	
Date:	

SECTION 8: COMFORTCARE HOME MEDICAL — PROVIDER VERIFICATION

For ComfortCare Home Medical office use only.

Provider Representative Name:	
Title:	

Provider Representative Name:	
Signature:	
Date:	
Provider Contact:	**comcare.store | Sandy Springs, GA**

ComfortCare Home Medical confirms that the equipment and charges listed above are accurate and were provided to the patient named on this form.

HOW TO SUBMIT THIS FORM

1. Complete all sections of this form.

2. Gather all supporting documents listed in Section 6.

3. Make copies of all documents for your records.

4. Submit this form and all attachments to your insurance company via their preferred method (mail, fax, or online portal).

5. Contact your insurance provider for claim status updates.

For questions about this form or your rental records, contact ComfortCare Home Medical at **comcare.store**.

Disclaimer: ComfortCare Home Medical provides this form as a convenience to our customers. Submission of this form does not guarantee reimbursement. Reimbursement decisions are made solely by the patient's insurance provider. ComfortCare Home Medical is not responsible for claim denials or delays.