roadrunner mobility
SERVICE SPECIALISTS

SUPPLIER REFERRAL - GENERAL

ATTN: CUSTOMER SERVICE *FAX #: 866-997-0779*

*Following information **must** be completed to its entirety*

PATIENT / LOCATION INFORMATION	**REFERRING SUPPLIER INFORMATION**
Pt Name (or Facility if app):	Name:
Contact (if app):	Address:
Address:	City, ST, ZIP:
City, ST, ZIP:	Phone:
Phone:	Contact:
Primary Insurance:	
Ins. ID #: DOB:	
PRESCRIBING PHYSICIAN INFORMATION *(if app)*	**PRODUCT INFORMATION**
Name:	Product Description:
Address:	Manufacturer:
City, ST, ZIP:	Model:
UPIN/NPI:	Serial Number:
ICD-9 Code(s) Billed:	Delivery Date: Warranty: <Yes> <No>
	Service Requested: <Repair> <Install> <Other>
	Specify for Other:

1.) How was the Product paid for?

☐ N / A ☐ CASH / SELF–PAY ☐ MEDICARE ☐ MEDICAID ☐ BCBS ☐ OTHER: _____

2.) Parts / Product to be shipped in advance: _____

3.) Comments: _____

Please Initial either A or B below:

A)_____ The service(s) requested **ARE** the sole financial responsibility of the referring supplier, and I, an authorized representative of the referring supplier, authorize RRM to perform service(s) and agree to the terms outlined in the Service Vendor Agreement. Please bill referencing Purchase Order _____ (optional).

B)_____The service(s) requested **ARE NOT** the financial responsibility of the referring supplier. Please bill the appropriate insurance and/or individual.

I, the undersigned, attest the information supplied on this referral is accurate, and agree to the financial responsibilities as initialed above. I furthermore attest that I am an authorized signer on behalf of the referring supplier listed above.

Name: _____ Title: _____
Print Name

Name: _____ Date: _____
Signature

CORPORATE OFFICE:
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1-800-467-2668