Notes/Comments/Attach Rx's Here
- Please date all notations -

Better Living Now, Inc.
Order In Take Form

Referral
Ordered By: Referral Source | Phone#: | Order Date:

Patient
Acct#/SS# | Insured ID# | Sex: M F
Patient's Last Name | Patient's First Name | MI: | Rel To Member: M S C

Patient Address
Address 1: | Apt#: | Date of Birth: DOB
Address 2: | Height: | Weight:
City: | State: | Zip Code: | Diagnosis

Emergency Contact: Next of Kin | Emergency Contact Phone#:
Functional Limitations? ☐ Yes ☐ No | Language Barrier? ☐ Yes ☐ No
Prior DME History? ☐ Yes ☐ No

Date of Surgery: Date of Surgery
Does Patient Live Alone? ☐ Yes ☐ No | Bedridden? ☐ Yes ☐ No
Infectious Disease to be aware of? ☐ Yes ☐ No

Delivery
Nearest Cross Streets/Directions: | Phone#: Patient Phone#
Date: Delivery Date | Time: Delivery Time
☐ BLN Truck ☐ Rate Shop
☐ UPS ☐ USPS ☐ Airborne
☐ Regular ☐ 2nd. Day
☐ Next Day ☐ Saturday

Employer: Member's Employer

Member
Acct#/SS#: | Member's Insured ID#: Member's ID# | Sex: M F
Member's Last Name: | Member's First Name: | MI: | Date of Birth:

Called Insurance Notes:

Primary Insurance
BLN Client#: | Primary Insurance: | Group/Policy#:
Address: **Effective:** | Phone#:
City: | State: | Zip Code:
Authorization#: Pre-Authorization | Eligibility Verified By:

Physician Information
Physician Name
Address
City | State | Zip Code
DEA | State License#
UPIN | Dr. Phone#

Secondary Insurance
Secondary Insurance Member's Name: | ID#:
BLN Client#: | Primary Insurance: | Group/Policy#:
Address: **Effective**: | Phone#:
City: | State: | Zip Code:
Phone#: | Authorization#: | Eligibility Verified By:

Products Ordered

Qty	Product Number	Rx# - Presc#	Total Charges	Co-pay/ Deductible

Insurance A/R (9) $_____ Good RX on file_____New Rx attached Consumer A/R (8)$_____