DME Patient Form

Patient Last Name (Please Print)	First Name	Middle Initial

Date of Birth:	**Gender:** ◯ M ◯ F	**Social Security Number:**
Facility/Organization:	**Service Start Date:**	**Primary Doctor:**
Payee:	**Payee's Relationship:**	**Payee's Address:**
Payee's Phone #:	**Check One:** **Medicare** ☐ **Medicare Advantage** ☐	**Secondary Insurance:**
Medicare #/info:	**Medicare Advantage #/info:**	

****Please include a copy of insurance card (both sides):**

Privacy Notice

I certify that I have received a copy of the privacy notice (HIPPA) and have reviewed the document. I acknowledge that Big Sky Managed Care, LLC is committed to protecting my health information.

Signature:_____Printed Name:_____
Date:_____

I understand that I am financially responsible to Big Sky Managed Care, LLC. for all charges incurred by the above-named patient, including copays, collection fees, etc. All non-covered medications and supplies will be billed to the patient or responsible party, unless prohibited by state regulations. All statement balances shall be paid in full unless other arrangements are made.

Resident or Responsible Party: _____Date:_____

900 13th Ave S
Great Falls, MT 59404

406-315-1989 Phone
406-315-1988 Fax

DME
BIG SKY
MANAGED CARE Rx

900 13th Ave S
Great Falls, MT 59404

406-315-1989 Phone
406-315-1988 Fax