

VACURECT™ PRESCRIPTION & ASSIGNMENT OF BENEFITS FORM

Complete the order form below and **MAIL** or **FAX** back to (See Box on the Right). Please contact us with any questions Toll Free at 1.866.813.3621.

This information will be provided discretely and for Insurance billing purposes only to **Bonro Medical, Inc.** who will contact you prior to fulfillment of order regarding any issues with your insurance coverage.

Please Return to:

THE FITZZ GROUP, INC.
3250 NE 1st Ave Ste 320
Miami, FL 33137

Fax: 786.879.8641

Toll Free: 1.866.813.3621
www.fitzz.com

ASSIGNMENT OF BENEFITS:

I authorize **Bonro Medical, Inc.** to file for my insurance benefits for my purchase*.

Patient Signature (**Required**): _____ Date: _____

*You will be responsible for paying Bonro Medical, Inc. the total amount of your unmet Medicare deductible or any amount not covered by your insurance. Medicare cannot be through an HMO without prior authorization and you cannot have purchased a VED within the last 5 years.

PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Birth Date: ____/____/____

E-mail: _____

INSURANCE INFORMATION:

We will verify your benefits and in many cases your "Out of Pocket" Cost is little or nothing. Complete the Patient Information section above, Insurance section below and have your physician complete the prescription section. Return this form with copies of the **back and front of your insurance cards**.

Primary Policy: _____ Policy #: _____

Group #: _____ Policy Holder's Name: _____

Secondary Policy: _____ Policy #: _____

Group #: _____ Policy Holder's Name: _____

Other Insurance Policy Information: _____

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(Page 2 of 2)

PRESCRIPTION FOR THE VACURECT™ VACUUM THERAPY SYSTEM

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ FAX: (_____) _____ - _____

Email Address _____ Specialty _____

My patient has been diagnosed with Organic Impotence (Code - 607.84) as a result of the following condition(s):

- | | |
|--|------------------------------|
| ___ 185 Carcinoma of the Prostate | ___ 401.9 Hypertension |
| ___ 188.9 Carcinoma of the Bladder | ___ 952.9 Spinal Cord Injury |
| ___ 443.9 Peripheral Vascular Disease | ___ 154.0 Colorectal Cancer |
| ___ 250.00 Non-Insulin Dependent Diabetes Mellitus | |
| ___ 250.01 Insulin Dependent Diabetes Mellitus | |

Other: _____

Physician Signature: _____ **Date:** ____/____/____

NPI #: _____
(Required for Medicare Orders)

PROVIDE COPIES OF ALL INSURANCE CARDS (FRONT & BACK)

This form is offered as a courtesy to the customers of The Fitzz Group, Inc. All insurance covered products are provided through BONRO MEDICAL, INC. whose Toll Free Number is (877) 266-7699.