

# Courtesy Billing Information Form



**PHYSICIAN'S PRESCRIPTION REQUIRED**

We must have a prescription signed by your physician sent to Freedom2Go before we can ship your order. Please choose one of the following methods to forward this information.

E-Mail Address: sales@freedom2go.com

Fax Number: (325) 437-1581

Mailing Address P.O. Box 2802

Abilene TX 79604-2802

\_\_\_ I have read and accepted the terms, conditions, policies, and procedures of Freedom2Go, LLC.

\_\_\_ I would like Freedom2Go to file a courtesy claim to my insurance on my behalf.

Patient Information		Insured information (as appears on insurance card)	
Patient Name	_____	Name	_____
Email	_____	Address 1	_____
Address	_____	Address 2	_____
City	_____	City	_____
State	_____	State	_____
Zip	_____	Zip	_____
Phone	_____	Phone	_____
Date of Birth	_____	Date of Birth	_____
Gender	_____	Social Security #	_____
Height	_____	Relation to Patient	_____
Weight	_____	Employer	_____

Insurance Company Information		Physician Information	
Co Name	_____	Name	_____
Address 1	_____	Address 1	_____
Address 2	_____	Address 2	_____
City	_____	City	_____
State	_____	State	_____
Zip	_____	Zip	_____
Phone Number	_____	Phone	_____
Policy Number	_____	Fax	_____
Group Number	_____		