



Stamen Medical Systems - Order Form

4806 Technology Drive – Martinez, GA 30907
1-866-506-7107 (phone) / 1-706-863-8882 (fax)

1. Patient Information:

Patient Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Phone No: _____ Birth Date: _____
 Product Desired: _____
 Medicare Policy No: _____
 Secondary Insurance Company Name: _____
 Telephone No: _____
 Secondary Policy No: _____
 Plan/Group No: _____

2. Assignment of Medicare Benefits:

I authorize the equipment supplier to file for my insurance benefits for my purchase.

***Signature required*

Patient Signature: _____ Date: _____

3. Product Selection and Price: *

Erec-Tech™ B.O.S.	_____	\$545.00
Erec-Tech™ M.O.S.	_____	\$495.00
Ultimate Tension System		
1 – System	_____	\$ 19.00
2 – Systems	_____	\$ 30.00
3 – Systems	_____	\$ 39.00

4. **Payment Method**

- Check
- Money Order
- American Express
- Master Card
- Visa
- Discover

Charge Card No: _____

Expiration Date: _____

Signature: _____

Non-Medicare Payment Calculation: _____

Price of unit being purchased: _____

Georgia Residents add 7% Sales Tax: _____

Shipping & Handling (\$14.00): _____

Total: _____

*If you have Medicare Part B, you only need to fill out the form (completely), and mail/fax it back in with a copy of your Medicare Card (front & back) and a patient support specialist will contact you within 24 hours to process your order.

Allow 1-2 weeks for delivery

**You are responsible for paying Stamen Medical Systems the total amount of your unmet Medicare deductible or any amount not covered by insurance. Proof of paid deductible is required. We cannot bill through an HMO without prior authorization. You must sign and date the Assignment of Medicare Benefits section (see above).

5. **Physician Information:**

Physician Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone No: _____ Email: _____

Specialty: _____

The Patient's Erectile Dysfunction is: (Please Check)

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

Other: _____

Please describe patient's reason for erectile dysfunction:

UPIN No: (Medicare Required)

"I prescribe and request an Erec-Tech™ System for my patient named above because it is medically necessary."

Physician Signature: _____

Date: _____

Patient must have physician information and signature completed before the order is placed.

Physician Office Request Section

Please send replacement brochures

Other: _____



Customer Support: 1-866-506-7107

Fax: 1-706-863-8882

www.stamenmedicalsistemas.com