Delivery Receipt and Authorization for Payment

Patient Name: _____ Date:_____

I have received _____ individual Dr. Comfort (style: _____) "extra-depth" shoes and (choose one):

- ☐ _____ individual Dr. Comfort full contact custom diabetic inserts (A5513 compliant). The inserts were made from a cast/bio-foam impression of my feet.
- ☐ _____ individual Dr. Comfort Elite inserts (A5512 compliant). The inserts were heat-molded to my feet to obtain full contact per my medical condition(s).

I am satisfied with the fit and authorize Medicare and my supplemental insurance carrier to pay _____ directly. I understand that Medicare pays for up to one pair of shoes (2 individual) and 3 pairs of inserts (6 individual) per calendar year. I understand that I am responsible for any deductible and unpaid balance that Medicare or my co-insurance does not cover. I have not received any other shoes or inserts under this plan from any other supplier in this calendar year.

Patients Warranty Statement

Dr. Comfort will accept returns of any Dr. Comfort shoes, for any reason, within thirty days of the shoes being dispensed. If, within thirty days, the Supplier notes that the shoes do not fit properly, Dr. Comfort will replace them at no charge with a properly fitted shoe. Dr. Comfort shoes that have been dispensed for a period of over thirty days will only be exchanged or credited at the sole discretion of Dr. Comfort. Any shoe that is returned must be returned in the original shoe box for proper credit.

Supplier Standards and Break in Procedure

The office staff has disclosed the CMS Medicare DMEPOS Supplier Standards to me and educated me on the proper break-in procedure for my Dr Comfort shoes.

Patient Signature: _____ Date:_____

Witness: _____Date:_____