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SERUM ORDER FORM

ACCT#____________________ DATE:____________________ DR:________________________

SERUM ORDERS AND POSTAGE MUST BE PREPAID, IN FULL, UNLESS COVERED BY INSURANCE

Prepay if you know your coinsurance amount for your vials.
Postage for mailing serum is **not** an insurance benefit. Prepay the postage fee with your order.

ORDER: Check vial size and delivery method: Mail serum ____ I will pick up ____

[ ] 6 injection vial [ ] 12 injection vial

[ ] Drops

Packaging/Postage: $3.50

Remit Pkg/Postage payment with your order.

Mark payment method:

[ ] Check # _______________

[ ] Credit Card: Visa MC Discover

Card #___________________________

Exp Date: _______________________

[ ] File my insurance (Plan name)

Be sure to supply us any change in insurance coverage

If we are not informed in a timely manner, and your insurance company denies payment for past filing deadline, you may be held responsible for payment of the full fee.

[ ] ****NEW INSURANCE INFO** [ ] PRIMARY INSURANCE [ ] SECONDARY INSURANCE

Ins. Plan name(s): ____

*****Attach a copy of the front and back of any new or updated insurance cards.***

Name ____ DOB: ____________________

Address ____ Work Ph: ____________________

____ Home Ph: ____________________

Order ahead 7-10 business days

DETACH ALONG THIS PERFORATION

USE THE ENVELOPE BELOW
FOR YOUR REMITTANCE