

Any Questions please
call 888-422-3044

ARMAC Authorization Dept.

Please fax to: 973-328-3753
with a copy of your prescription.

Contact Name: _____ Date of Fax: _____

Please fill out all areas of this form.

Patient Name: _____ Date of Birth: _____

Address: _____ Male or Female: _____

City, State, Zip: _____

Home Number: _____

Cell Number: _____

Is the injury due to: (please circle one if applicable)

Prescribing Doctor: _____

Auto Accident

Dr.'s phone #: _____

Worker's Comp

For what side: Right or Left or Both (please circle one)

Other: _____

Product / Description: _____

Date of Injury: _____

Claim #: _____

Insurance Information:

Primary Insurance: _____

Primary Subscriber Name: _____

Relation to Patient:

Policy Number: _____

Subscribers Date of Birth:

Group#: _____

Type of Plan: _____

Claims Address / Phone Number: _____

Secondary Insurance: _____

Primary Subscriber Name: _____

Relation to Patient:

Policy Number: _____

Subscribers Date of Birth:

Group#: _____

Type of Plan: _____

Claims Address / Phone Number: _____

Diagnosis Code or Description: (should be on your prescription form doctor, if not please ask Dr. for DX Code)

Have you received products from ARMAC before? Y or N

I authorize my physician to release to ARMAC Inc and for Armac to release to my insurer any needed information for this or a related claim.

Patient Signature: _____ Date: _____

*****Please fax this form in along with a copy of your prescription from your doctor to
973-328-3753 *****