



The Sensational Child Inc
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Delivery/Pickup Ticket

Delivery

Pickup

Service

Date: _____

Patient name:		Account #		
Address:		City:	State:	Zip:
Patient Phone/Cell:		Email address:		
<u>Qty</u>	<u>HCPCS Code</u>	<u>Description</u>	<u>Item Code #</u>	<u>Model / Serial #</u>

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to the undersigned supplier of the services described.

Patient or designee signature

Patient or designee name

Relationship to patient

Date