Purewick System Resupply Agreement

Patient Information

Name: _____

Date of Birth: _____

Medicare/Insurance ID: _____

Authorization for Ongoing Resupply
I understand that I have received a Purewick System and related supplies from Optimistic Healthcare Solutions, LLC (DBA OHC Pharmacy). I authorize Optimistic Healthcare Solutions to provide me with ongoing shipments of Purewick System supplies (including accessories, tubing, and other related items) as medically necessary and covered by my insurance plan.

Patient Responsibilities
- I confirm that I am currently using my Purewick System as prescribed by my physician.
- I agree to notify Optimistic Healthcare Solutions immediately if I stop using the device, switch devices, or no longer need supplies.
- I understand that Optimistic Healthcare Solutions may contact me before each shipment to confirm my continued use and need for supplies.
- I agree to sign or verbally confirm proof of delivery with each shipment, as required by insurance and Medicare guidelines.

Insurance & Billing
I understand that coverage is based on medical necessity and my plan's requirements. I authorize Optimistic Healthcare Solutions to bill my insurance for resupplies, and I accept financial responsibility for any amounts not covered (e.g., copays, deductibles, non-covered items).

Duration
This authorization remains in effect until I revoke it in writing, my provider discontinues my Purewick System prescription, or my insurance coverage changes.

Patient Signature: _____ Date: _____

OHC Pharmacy Representative: _____ Date: _____