



EBI Purchase Order Form

Date _____ EBI Patient ID Number _____ Ordering Physician/HCP Name _____
 Patient Name _____ Address _____
 Address _____ City _____ State _____ Zip _____
 City _____ State _____ Zip _____ Telephone Number _____
 Telephone Number _____ NPI Number _____
 Account / Facility Name _____ Account Payable Contact Name _____
 Address _____ Bill to Address _____
 City _____ State _____ Zip _____ City _____ State _____ Zip _____
 Telephone Number _____ Telephone Number _____
 Purchase Order Number _____ Email _____

Shipment Required _____ Yes / _____ No

PRODUCT INFORMATION			
Quantity	Item # / HCPCS Code	Product Type (BHS / OrthoPak® / SpinalPak® / Xstim)	Price

Authorized Individual Issuing Purchase Order
 Signature _____
 Print Name _____
 Signature Date _____


Authorized Individual Accepting Delivery
 Signature _____
 Print Name _____
 Serial Number _____ Coil Size _____
 Date Dispensed _____


NOTE: The Account/Facility is purchasing the durable medical equipment (DME) specified on this order and is responsible for billing and reimbursement. Coverage and payment are subject to payer discretion and policies. EBI makes no statement, promise, or guarantee concerning coverage determinations and/or payment levels by third-party payers.

Physicians or Healthcare Providers (HCP) are solely responsible for billing patients and third-party payers for the DME and assumes all risk of nonpayment. The Physician or HCP agrees they will not bill claims associated with the DME to Medicare or to any other government or commercial payers that prohibit physicians from billing for the provision of such items to their own patients. Payment terms shall be based upon agreements.

Territory Number _____ Sales Representative Number _____ Sales Representative Name _____

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 **Legal Manufacturer**
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