

**WILLIAM A. ALLEN CO.
26 MAIN STREET
LEOMINSTER, MA 01453
978-534-3111**

DATE: _____

I, _____ HAVE BEEN MADE AWARE THAT THE DME MERCHANDISE THAT I HAVE SELECTED IS CONSIDERED A DELUXE ITEM, DUE TO THE FACT THAT ITS RETAIL PRICE IS HIGHER THAN THE USUAL ALLOWABLE PRICE OF MY INSURANCE COMPANY. I AM WILLING TO PAY THE DIFFERENCE BETWEEN THE ALLOWABLE PRICE AND THE ACTUAL RETAIL PRICE OF THE DME MERCHANDISE. I UNDERSTAND THAT THIS UPGRADE FEE WILL BE CHARGED IN ADDITION TO ANY COPAY DUE IN ACCORDANCE WITH MY INSURANCE POLICY. MY INSURANCE COMPANY HAS INFORMED THIS PROVIDER THIS PROCEDURE IS ACCEPTABLE.

COST OF DME MERCHANDISE: _____

INSURANCE COMPANY'S ALLOWABLE: _____

PATIENT RESPONSIBILITY: _____

COPAYMENT DUE: _____

PATIENT'S SIGNATURE: _____