

Aircast Cryo/Cuff IC Prescription & Authorization Request Form

► **Website:** www.Hat-Trick-Sports.com ► **Phone:** 724-252-7223 ► **Fax:** 814-825-1205 ► **Email:** Sales@Hat-Trick-Sports.com



- ✓ *Fill out your shipping and credit card information.*
- ✓ *Secure your provider's signature on this form.*
- ✓ *Fax, email, or text us a picture of your form.*
- ✓ *Item can only be shipped to the USA & Puerto Rico.*

Product Quantity	Item Number	Price	Qty
IC Cooler Only	51A	\$119.99	
Cryo/Cuff IC Shoulder Regular	51A12A	\$204.98	
Cryo/Cuff IC Shoulder X-Large Strap	51A12AXL	\$204.98	
Cryo/Cuff IC Ankle	51A10A	\$189.98	
Cryo/Cuff IC Knee Medium	51A11A	\$189.98	
Cryo/Cuff IC Knee Large	51A12A	\$189.98	
Other _____			

* Please **Call Us for Expedited Shipping** rates. Otherwise, the item will be shipped with **FREE Ground Shipping**.

Patient Contact Information:

Name _____

Billing Address (as shown on credit card) _____

City _____ State _____ Zip _____

Shipping Address (if different from billing) _____

City _____ State _____ Zip _____

Phone Number (with area code) _____

Email _____

Payment Details:

Order Placed and Paid for Previously Online (Skip this Section)

Credit Card Type (VISA, MC, Discover, Amex) _____

Credit Card Number _____

Expiration Date _____

CVC (3 digit security code on back of card) _____

Signature _____ Date _____

*****This Section to be Filled Out by a Licensed Medical Provider:*****

I authorize the purchase of a Cryo/Cuff IC cold therapy unit for the patient named above. This patient is under my care and the use of this system, in my judgment, is indicated and medically necessary.

Physician or Provider Name _____ NPI# (Required) _____

Address _____

City, _____ State _____ Zip _____

Provider Phone Number _____

Provider Signature _____ Date _____