2020 Auto Resupply

Patient Name:_____ **Phone:** _____ **DOB:**_____

Current Mailing Address:_____

I am using the following machine: _____
I am using the following mask kit: _____
I am using the following cushion size: _____

I agree to receive my PAP therapy supplies at the following frequency:

A7031: Full face mask cushion	1 every month
A7032: Nasal Cushion	2 every month
A7033: Pillow Cushion	2 every month
A7038: Disposable filter	2 every month
A7030: Full face Shell	1 every 3 months
A7034: Nasal & Pillow Shell	1 every 3 months
A7037: Standard Tubing	1 every 3 months
A4604: Heated Tubing	1 every 3 months
A7035: Headgear	1 every 6 months
A7036: Chin Strap	1 every 6 months
A7039: Non Disposable Filter	1 every 6 months
A7046: Water Chamber	1 every 6 months

X___ I would like all supplies auto shipped
X___ I will call when in need of supplies
X___ I would like to discontinue auto-shipments.
X___ I received a handout with all DME Allowables

I understand it is my responsibility to update the clinic with updated insurance information. I also understand by signing below I will be responsible for anything insurance does not cover.

Patient Signature: _____ **Date:**_____

DSC Stakeholder: _____ **Date:**_____

Mail or fax this form to:

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