



Assignment of Benefits/Medical Information Release CPAP/Bi-Level Items/Supplies

Patient Name

Street Address

City, State, Zip

Phone

Email Address

Thank you for your interest in receiving **PAP/RAD Supplies** from American HomePatient. We are pleased to serve as your provider of choice for home medical equipment and supplies.

Your order will be sent to you once we have received 1) this form, signed and dated, and 2) the order from your doctor and any additional records which may be required.

I attest the above information is correct. I authorize the direct billing to Medicare, Medicaid, Medicare Supplemental, and/or private health insurance on my behalf by American HomePatient and/or its corporate affiliates, agents and assigns. If signed by someone other than the patient, I acknowledge I have the authority to sign on behalf of the patients. I have received, read and understand THE TERMS OF AGREEMENT AND AGREE TO BE BOUND BY THE TERMS OF AGREEMENT. I acknowledge receipt of the Company's Notice of Privacy Practices.

Patient Signature

Print Patient Name

Date

AHOM REP

If someone other than the patient is signing this form, please complete the following information for the person signing this form.

Legal Representative Signature

Legal Representative Print Name

Date

Print Patient's Name

Relationship to patient

Reason patient cannot sign

Street Address of person signing

City, State, Zip Phone

Once completed, submit form as follows:

Fax Toll Free at 866-839-0102 or
Mail to 5213 Linbar Drive Ste. 400, Nashville, TN 37211