Print Form

AMERICAN HOMEPATIENT

ASSIGNMENT OF BENEFITS
PAP/RAD Supplies

Patient Name		
Street Address		
City: State: Zip		
Phone:	( )	email

Thank you for your interest in receiving **PAP/RAD SUPPLIES** 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 as soon as we have received 1) this form, signed and dated, and 2) the order from your doctor and any additional records required.

Medicare Notification of Inexpensive/Routinely Purchased Option Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount. I elect the following;		
I elect to	☐ Rent ☐ Purchase the HUMIDIFIER	☐ **N/A**

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 I acknowledge I have the authority to sign on behalf of the patient. Further, by SIGNING BELOW I hereby expressly agree to receive calls by or on behalf of American HomePatient and/or its corporate affiliates, agents and assigns regarding treatment options, health-related information, disease-management programs, wellness programs, products, services, or other community-based initiatives or activities relating to my care. 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's Signature **Patient's Name Print** **Date**

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

_____ _____

Print Patient's Name Date

_____ _____

Legal Representative Signature Legal Representative PRINT NAME

_____ _____

Relationship to patient Reason why the patient is not able to sign

Street Address _____

City: State: Zip: _____

Phone: (____) _____

Once completed, submit form as follows:
Fax toll Free at 866-839-0102 or mail to:
5213 Linbar Drive, Suite 400, Nashville, TN 37211