Remedy Medical Supply Inc

3717 E Thousand Oaks Blvd, Ste 212, Westlake Village, CA 91352 805-267-1858 P 805-435-0432 F info@remedymedicalsupply.com

Auto-Ship CPAP/BiPAP Supply Program

Required Information

Name: ______________________________________ Date: ____________________

Date of Birth: _______________________________ Daytime Phone: ___________________________

Email Address: ____

Address: ____

Insurance Company: _______________________________________ ID# ___________________________

Doctor Name: ____ Phone: ___________________________

☐ YES, I am subscribing to the Remedy Medical Supply Auto-ship Program for my CPAP/BiPAP Supplies. I would like my supplies sent to my address above. I am providing my email in order to receive important information regarding my supplies or my account. I understand that Remedy Medical Supply will never sell or otherwise transfer my information to any other company with the exception of information supplied to medical professionals, insurance companies, etc directly involved with my care related to my sleep apnea, or collection of my account.

☐ I am requesting the following supplies to be shipped to me according the guidelines of my current insurance provider.

Every 3 months

- ☐ Tubing 1
- ☐ Full Face Cushion 1
- ☐ Nasal Cushion 2/month
- ☐ Nasal Pillows 2/month
- ☐ Cushions for oral/nasal device 2/month
- ☐ Mask

Every 6 months

- ☐ Headgear 1
- ☐ Chin Strap 1
- ☐ Water Chamber 1
- ☐ Non-Disposable Foam Filter 1 (when applicable)

Most insurance companies allow a 3 month supply to be mailed, others require supplies to be sent monthly instead. We will determine your situation upon verification of your insurance and send supplies accordingly.

☐ I understand that a current prescription is needed in order to ship certain equipment and I hereby grant permission for Remedy Medical Supply to obtain the necessary prescription from my physician and for my related medical records to be released to Remedy Medical Supply in order to ship my supplies and bill my insurance.

I understand that I am responsible for the deductible and co-insurance amounts left after my insurance has processed my claim. I promise to pay those amounts to Remedy Medical Supply. In the event that my insurance company pays me directly, I agree to forward those funds immediately to Remedy Medical Supply. I agree that the unpaid balance of my bill extending past 30 days after insurance has paid/processed my claim will be subject to 1.5% monthly service charge. I agree that I am responsible for fees and costs associated with collecting the balance on my account.

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Signature Date

FAX BACK TO 805-435-0432