

SLEEP DIAGNOSTICS, INC.
CPAP supplies, made simple

A little less to remember. A little more peace of mind.

Hello there!

We are pleased to offer an automatic supply shipment program to help you stay stocked with your CPAP replacement supplies. To enroll, please complete the attached form and return it to our team.

The little details

- Please notify our billing department whenever your insurance information changes.
- A flat \$5 shipping fee applies to monthly autoship orders, except orders containing only filters. This fee is not covered by insurance.
- Your autoship authorization remains in effect until you terminate the program.
- If you have an implantable medical device and use a mask with magnets, contact our office before using the mask.

Send it our way

Return your completed form to one of our offices or email it to:

shaylynn@sleepwellmt.com

Questions? We're here for you.

HELENA	MISSOULA	BUTTE
900 N. Montana Ave., Ste A9	1211 S. Reserve, Ste 203	400 W. Granite
Helena, MT 59601	Missoula, MT 59804	Butte, MT 59701
Phone: (406) 449-8999	Phone: (406) 542-4784	Phone: (406) 782-4595
Fax: (406) 449-8989	Fax: (406) 543-1150	Fax: (406) 782-4355

Please contact us with any questions. We appreciate the opportunity to support your therapy.

Warmest regards,

The Sleep Diagnostics Sleep Team

SLEEP DIAGNOSTICS, INC.

Your autoship sign-up

Complete your information and select the supplies you would like shipped.

1 | Patient & insurance information

Patient name: _____ DOB: _____ Date of setup: _____
Phone: _____ Email: _____
Insurance company: _____ Member ID: _____ Group #: _____

2 | Current equipment

CPAP machine manufacturer / model: _____
Full-face mask (style / size): _____
Nasal mask (style / size): _____
Nasal pillows (style / size): _____
Headgear (style / size): _____
Heated tubing (style / size): _____ Non-heated tubing (length): _____
Approximately when did you last receive a new mask? _____

3 | Choose your autoship supplies

Mark the items you want shipped. Write your preferred interval and starting month/year. Listed allowances are from the original form and may vary by insurance plan.

SUPPLY	LISTED ALLOWANCE	SEND EVERY	START (MM/YYYY)
☐ Mask frame (nasal or full face)	1 every 3 months	_____ months	_____
☐ Exhalation port	1 every 3 months	_____ months	_____
☐ Headgear	1 every 6 months	_____ months	_____
☐ Nasal / nasal-pillow cushion	2 per month	_____ months	_____
☐ Full-face cushion	1 per month	_____ months	_____
☐ Non-heated tubing	1 every 3 months	_____ months	_____
☐ Heated tubing	1 every 3 months	_____ months	_____
☐ Disposable filters	2 per month	_____ months	_____
☐ Water chamber	1 every 6 months	_____ months	_____
☐ Non-disposable filter	1 every 6 months	_____ months	_____

☐ No changes to my existing supply selections.

Special notes / requests: _____

I request shipment of the supplies selected on the preceding page beginning in the month and year indicated. This authorization remains in effect until I terminate the program.

Terms & acknowledgments

1. Assignment of insurance benefits

I authorize Sleep Diagnostics, Inc. any insurance benefits otherwise payable to me for the services provided to me by Sleep Diagnostics, Inc. I also authorize my insurance companies to furnish to an agent of Sleep Diagnostics, Inc. any information pertaining to my insurance benefits and status of claims submitted by Sleep Diagnostics, Inc. for services rendered. I further authorize Sleep Diagnostics, Inc. to release to my health insurance companies and all information pertaining to me for benefit determination.

2. Financial responsibility

I understand that my insurance coverage may not pay the total cost of the service provided to me by Sleep Diagnostics, Inc. I acknowledge my obligation to pay the balance between what my insurance coverage will pay and what Sleep Diagnostics, Inc. can charge for these services. I agree to remit Sleep Diagnostics, Inc. any payments made directly to me by my insurance company for services provided by Sleep Diagnostics, Inc.

3. Collection costs

I understand that should I default on my payment of my account and collection agency services are required, all costs of collection, including attorney fees will be added to the balance of my account.

4. Additional collection provision

I understand that if I default on payment and collection agency services are required, collection costs of up to 45% of the balance, including attorney/court costs, may be added. This agreement remains in effect for services provided within 90 days of signing.

5. Masks with magnets

If I have an implantable medical device and use a mask with magnets, I will contact the office.

6. Shipping fee

I authorize a \$5.00 flat shipping fee each month for supply shipments, except filters-only shipments. I understand the shipping fee is not covered by insurance.

Patient signature: _____ Date: _____