



PATIENT ASSIGNMENT OF BENEFITS HOME MEDICAL EQUIPMENT

Medical Information Release: I hereby authorize the above practice to disclose or receive any or all information relating to my evaluation at this office, including copies of my diagnostic test results, to or from my attending physician and/or such physicians as may be selected by my attending physician, at his or her discretion, for the purpose of obtaining further diagnosis and/or treatment which he or she believes is indicated.

PAP Compliance: Your insurance company requires us to follow up with you regarding the use of your pap equipment. **You are required to follow up with the ordering physician within 31-90 days after the setup of your machine.** During this visit your physician will document that you are using and benefiting from pap therapy as well as your compliance in using the machine. A download report will be provided to show your compliance. If you are not compliant with the use of the machine we will work with you to get compliant. If we are unsuccessful in getting your compliance you will need to return your machine to us or you will be billed for the balance of your machine.

I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

I understand that my estimated copay for my PAP supplies and equipment will be \$_____. Insurance carriers choose to rent your machine for a period not extending past 10 months. Supplies are continuous every 90 days.

PAP Equipment warranty: Standard coverage is 2 years for all machines. Please refer to the manufacturer's warranty and manual for complete details.

I have read and understand the above items. I understand my pap equipment and its intended use. I have been instructed on the proper maintenance and cleaning techniques.

Complaint Protocol: If you are unhappy with the services provided by this company please call Rik Wade at (330)572-1011 x 177. We will respond within 5 calendar days. In the event your complaint is not resolved to your satisfaction you can contact our accrediting organization The Compliance Team at www.thecomplianceteam.org or by calling 1-888-291-5353.

Capped Rental/ Purchase: Insurance carriers choose to rent your machine for a period not extending past 10 months. Once this rental period has been reached, you own the machine.

I have received instructions and understand that my insurance carrier defines the PAP Equipment that I received as being a capped rental item.

- Insurance will pay a monthly rental fee for a period not to exceed 10 months, after which ownership of the equipment is transferred to the beneficiary.
- After ownership of the equipment is transferred to the beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair.
- Examples of this type of equipment include: Hospital beds, wheelchairs, alternating pressure pads, continuous airway pressure (CPAP) devices, and patient lifts.

Assignment of Benefits: I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Unity Health Network and/or any of our corporate affiliates for any medical supplies and/or medications furnished to me by Unity Health Network. I authorize any holder of medical information about me to release to Unity Health Network, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services.

UNITY HME is NOT a contracted provider for Medicare or Medicaid. Should your insurance change to Medicare, Medicaid or any other Insurer with whom we are not contracted with during within the 10 month capped rental, you could be required to return you PAP unit or become self-pay for the balance, if you choose. Please notify Unity HME immediately of any changes to your insurance coverage.
_____ (*Initial*)

Printed Patient Name _____

Patient Signature _____ Date _____