



CPAP / BIPAP
Auto Mail Verification Form

I, _____, would like to utilize Lakeland Health Services' CPAP/BIPAP Auto-mail program for my on-going CPAP/BIPAP supplies. I would like to have the following supplies shipped to me every:

Mask & headgear

3 months

Tubing

Other ___ months

Filters

* Call to order humidifier chamber as needed *

Shipping Address: _____

Insurance Company: _____
ID or Policy #: _____
Group: _____

Please bill my insurance company for covered supplies. I realize I am financially responsible for any amount not covered by my insurance plan, to include deductible and co-pay, and will notify Lakeland Health Services immediately of any changes in my insurance coverage or status.

I understand that I can discontinue my participation in the Auto-mail program at any time by notifying Lakeland and requesting to be removed from the program. Further, if my therapy becomes no longer medically necessary I must notify Lakeland immediately of this change in status.

Signed: _____

Date: _____