AUTO MAIL REQUEST FORM

I would like to utilize Lakeland Health Services' PAP Auto-mail program for my on-going PAP supplies. I would like to have the following supplies shipped to me every

☐ Mask	__3 mo	__6 mo	__9mo	__12 mo	__Other___mo
☐ Water Chamber		__6 mo		__12 mo	
☐ Tubing	__3 mo	__6 mo	__9mo	__12 mo	__Other___mo
☐ Chin Strap	__3 mo	__6 mo	__9mo	__12 mo	__Other___mo
☐ Disposable Filters	__3 mo	__6 mo	__9mo	__12 mo	__Other___mo
☐ Non-Disposable Filters		__6 mo		__12 mo	
☐ Cushions/Pillow (qty 6)	__3 mo	__6 mo	__9mo	__12 mo	__Other___mo

Please Ship supplies to me at:

☐ Current address on file

☐ New address:_____

Please bill my insurance company for covered supplies. I realize I am financially responsible for any amount not covered by my insurance plan 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.

Name (Printed): _____ Chart#:_____(optional)

Signed:_____ Date:_____

Phone or email in case of questions:_____

Email to: AmandaB@LHSsleep.com Fax to: 763-576-1660