LAKELAND
HEALTH SERVICES

PAP SUPPLIES REQUEST FORM

I would like to have the following supplies shipped to me:

- ☐ Mask
- ☐ Water Chamber
- ☐ Tubing
- ☐ Chin Strap
- ☐ Disposable Filters
- ☐ Non-Disposable Filters
- ☐ Nasal Cushions/Pillow (qty 6)
- ☐ Full Face Mask Cushions/Pillows (qty 3)

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