AAA MEDICAL SOLUTIONS
Getting it done right...right now.

Fax: 208.577.2893

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EQUIPMENT COURIER / DME INFO

NAME:_____

CITY:_____ **ST:**_____

PHONE: (_____)_____

FAX: (_____)_____

PATIENT INFORMATION

INSURANCE INFORMATION

Rev. 5

PATIENT NAME:_____ DOB_____

PHONE: (_____)_____ SSN:_____ GENDER: ☐ M ☐ F

MAILING ADDRESS:_____

CITY:_____ STATE:_____ ZIP.:_____

PLEASE CHECK YOUR PRIMARY INSURANCE TYPE:

☐ MEDICARE MEDICARE NUMBER: _____ (ATTACH COPY OF MEDICARE CARD, FRONT AND BACK)

☐ MEDICAID MEDICAID NUMBER:_____ STATE:_____

☐ PRIVATE (PLEASE FILL OUT SECTION BELOW)

PLEASE FILL OUT YOUR SECONDARY / PRIVATE INSURANCE INFORMATION, IF APPLICABLE:

INSURANCE NAME:_____ PHONE: (_____)_____

ADDRESS: _____ CITY, STATE, ZIP:_____

POLICY #:_____ GROUP #:_____

POLICY HOLDER'S NAME:_____ ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

ASSIGNMENT OF BENEFITS / STATEMENT OF AUTHENTICITY / MEDICAL RELEASE - **REQUIRED**

I, the undersigned, hereby authorize payment be made on my behalf to AAA Medical Solutions, Inc. for authorized insurance benefits, including Medicare, if I am a Medicare beneficiary. I understand that I am financially responsible to AAA Medical Solutions, Inc. for any charges not covered by health care benefits. A monthly finance charge of 1% (12% annually) will be imposed on any oustanding amount over 30 days old in addition to a $5 monthly statement fee. The monthly statement fee will be added to the outstanding amount from the previous month. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by AAA Medical Solutions, Inc. and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand by signing below, that I am accepting these terms and financial responsibility as explained above for all payment for products and or services received. **The maximum charge for each test performed is $49.00.**

I, the undersigned, certify that I am the recipient of the oximetry testing unit and that the test was actually performed on me at the dates and times specified below during the night and/or while asleep. I also certify that I have not, and to my knowledge nor has the courier of this test, tampered with or altered this test in any way and that it will be downloaded in its original form.

I, the undersigned, authorize AAA Medical Solutions, Inc. to use and disclose my health information for the purpose of treatment, obtaining payment or supporting the health care operations of my ordering physician. I also authorize AAA Medical Solutions, Inc. to use facsimile with confidential disclosure of my results to my ordering physician and the DME supplier listed above. (Note: You may call us using the number above if you would like to review our Notice of Privacy Practices before signing below.)

PATIENT SIGNATURE: X _____ **DATE:** _____

If signing for patient, please indicate relationship to the patient_____

Test Done On:	**Test Started:**	**Test Ended:**
☐ Room Air ☐ O^2 LPM____ ☐ CPAP / BIPAP	Date: _____ Time: _____	Date: _____ Time: _____

ACTIVITY LOG:

TIME	ACTIVITY DESCRIPTION
____:____ AM / PM	_____
____:____ AM / PM	_____
____:____ AM / PM	_____

☐ **PLEASE PROVIDE FULL REPORT**

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