SLEEP DIAGNOSTICS, INC.

Helena Office
900 N. Montana Ave. Ste A9
Helena, MT 59601
Phone (406) 449-8999
Fax (406) 449-8989

Missoula Office
1211 S. Reserve, Ste 203
Missoula, MT 59804
Phone (406) 542-4784
Fax (406) 543-1150

Butte Office
400 W. Granite
Butte MT. 59701
Phone (406)782-4595
Fax (406) 782-4355

Dear Valued CPAP customer,

Please complete the enclosed Autoship form, if you would like to receive CPAP supplies.

- *Please notify our billing department if your insurance has changed.*
- *You will be billed a $20.00 shipping fee for a 12-month period.*
- *This Autoship form will remain valid until the patient terminates.*
- *If you have an implantable device and use a mask with magnets, please contact our office.*

Please return the completed form to office or email it to sarah@sleepwellmt.com or shaylynn@sleepwellmt.com.

Please contact us with any questions.

Warmest Regards.

Sleep Diagnostics Sleep Team

Patient Name: _____ DOB: _____ Date of Set Up

Phone # _____ Email

Current Insurance _____ ID # _____ Grp #

PLEASE FILL IN THE INFORMATION BELOW:

CPAP MACHINE MANUFACTURER AND MODEL: _____

FULL FACE FRAME AND CUSHION STYLE: _____ SIZE: _____

NASAL MASK FRAME AND CUSHION STYLE: _____ SIZE: _____

NASAL PILLOW FRAME AND CUSHION STYLE: _____ SIZE: _____

HEADGEAR STYLE: _____ SIZE: _____

HEATED TUBING STYLE: _____ SIZE: _____

NON-HEATED TUBING LENGTH (STANDARD IS 6 FT): _____

HOW LONG AGO (APPROXIMATELY) SINCE YOU GOT YOUR LAST MASK? _____

PRODUCT	ALLOWED AMOUNT	FREQUENCY CHOICE			Start sending these specific supplies on this MONTH and YEAR	
MASK FRAME NASAL OR FULL FACE	1 EVERY 3 MONTHS	1 EVERY		MONTHS		
EXHALATION PORT	1 EVERY 3 MONTHS	1 EVERY		MONTHS		
HEADGEAR	1 EVERY 6 MONTHS	1 EVERY		MONTHS		
MASK CUSHION (nasal or nasal pillows)	2 PER MONTH	2 EVERY		MONTHS		
MASK CUSHION (full face)	1 PER MONTH	1 EVERY		MONTHS		
TUBING (non- heated)	1 EVERY 3 MONTHS	1 EVERY		MONTHS		
TUBING (heated)	1 EVERY 3 MONTHS	1 EVERY		MONTHS		
DISPOSABLE FILTERS	2 PER MONTH	2 EVERY		MONTHS		
WATER CHAMBER	$40.00 CASH FEE	1 EVERY		MONTHS		
NON-DISPOSABLE FILTER	1 PER 6 MONTHS	1 EVERY		MONTHS		

☐ ***Please check if there are no changes made.***

SPECIAL NOTES/REQUESTS:

_____

Please ship me the supplies checked starting on the month and year that is stated above.
This invoice is valid for one year from the date of signature.

1. Assignment of Insurance Benefits: I authorize Sleep Diagnostics, Inc. any insurance benefits otherwise payable to me for the services provided to me by Sleep Diagnostics, Inc. I also authorize my insurance companies to furnish to an agent of Sleep Diagnostics, Inc. any information pertaining to my insurance benefits and status of claims submitted by Sleep Diagnostics, Inc. for services rendered. I further authorize Sleep Diagnostics, Inc. to release to my health insurance companies and all information pertaining to me for benefit determination.
2. Acknowledgement of My Financial Responsibility: I understand that my insurance coverage may not pay the total cost of the service provided to me by Sleep Diagnostics, Inc. I acknowledge my obligation to pay the balance between what my insurance coverage will pay and what Sleep Diagnostics, Inc. can charge for these services. I agree to remit Sleep Diagnostics, Inc. any payments made directly to me by my insurance company for services provided by Sleep Diagnostics, Inc.
3. I understand that should I default on my payment of my account and collection agency services are required, all costs of collection, including attorney fees will be added to the balance of my account.
4. I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 45% of the balance, including attorney/court costs will be added to the balance of my account. This agreement shall remain in effect for all services provided within 90 days from the date of signing this agreement.
5. If you have an implantable device and use a mask with magnets, please contact our office.
6. I agree to authorize an annual shipping charge of $20.00 that will be assessed to my account and is not covered by insurance.

Patient Signature _____ **Date** _____