



## Medicare Beneficiary Statement

# Evaluation of Continuous Positive Pressure Device

Patient	Doctor	Insurance
		<input type="checkbox"/> Medicare reg. <input type="checkbox"/> BCBS of ND <input type="checkbox"/> Self-pay patient

Dear Patient,

Our records indicate you currently rent a BIPAP or CPAP machine from our company and Medicare requires us to send you this follow-up letter every three months. Please complete this form by answering the questions below.

1. Do you currently use your BIPAP or CPAP machine every night?

Yes       No\*

*\*If you no longer use your breathing machine, please call our main office at 701-364-0589 to schedule a pick up as we cannot bill Medicare if you no longer need it.*

2. How many hours per night do you use the machine? \_\_\_\_\_ hrs.

3. Will you continue to use the BIPAP or CPAP machine in the future?

Yes       No

If you have questions about this form or billing, please call 888-266-0887.

So that we can continue billing Medicare for you, please sign, date and **fax this form to our office at 701-356-5798** within 10 days. If someone other than the patient completed the questionnaire, indicate his/her name and relationship to patient (for example; spouse, daughter, son, supplier of machine, etc.). Thank you for your continued business.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_