ADVANCED HEALTH SERVICES, INC.

YOUR SOURCE FOR QUALITY PAP CARE AND SUPPLIES

COMMUNITY HEALTH CHAP ACCREDITATION PROGRAM

Advanced Health Services
680 North Lake Shore Drive
Suite 1210
Chicago, IL 60611
Phone: (312) 587-0926
Fax: (708) 364-9607

Advanced Health Services
900 Technology Way
Suite 120
Libertyville, IL 60048
Phone: (847) 231-4507
Fax: (708) 364-9607

Advanced Health Services
1924 Springbrook Square Dr.
Naperville, IL 60564
Phone: (630) 527-0188
Fax: (708) 364-9607

Advanced Health Services
10646 West 165th Street
Orland Park, IL 60467
Phone: (708) 364-9606
Fax: (708) 364-9607

Advanced Health Services
2501 Compass Road
Suite 105
Glenview, IL 60026
Phone: (847) 768-9915
Fax: (847) 364-9607

Waiver of Insurance Coverage

I understand the following item(s) is a covered benefit under my insurance plan; however, the item(s) is not eligible for coverage at this time according to the Insurance allowed frequency of replacement supplies.

✓	Code	Description	Frequency	Price
	E0601	CPAP		$1,111.45
	E0601	APAP		$1,111.45
	E0470	BIPAP		$2,552.99
	E0471	ASV		$6,055.19
	E0562	Heated Humidifier		$230.54
	A4604	Heated Tubing	1/3mo	$31.11
	A7027	Oral/Nasal Mask	1/3mo	$95.70
	A7028	Oral Cushion	2/1mo	$27.03
	A7029	Nasal Pillow Oral/Nasal	2/1mo	$12.06
	A7030	Full Face Mask	1/3mo	$144.38
	A7031	Full Face Cushion	1/1mo	$53.40
	A7032	Nasal Cushion	2/1mo	$31.02
	A7033	Nasal Pillow	2/1mo	$21.74
	A7034	Nasal Mask	1/3mo	$90.02
	A7035	Headgear	1/6mo	$30.41
	A7036	Chinstrap	1/6mo	$11.83
	A7037	Regular(non-heated) Tubing	1/3mo	$31.28
	A7038	Disposable Filters 2pk	2/1mo	$7.02
	A7039	Non-Disposable Filters	1/6mo	$10.70
	A7046	Water Chamber	1/6mo	$14.93
			TOTAL:	**$**

I am aware the above item(s) is not eligible for insurance coverage at this time. I agree to receive the item(s) and agree to pay any out of pocket cost associated with this transaction. I understand that receiving this item(s) today will affect future eligibility.

_____ _____

Printed Name Date of Birth

_____ _____

Signature Date

For internal use only:

_____ _____ _____ _____

Witness Signature DOS SO# Claim#

FAX TO (708) 966-5341