ADVANCED HEALTH SERVICES, INC.

YOUR SOURCE FOR QUALITY PAP CARE AND SUPPLIES

ADVANCED HEALTH REPLACEMENT MACHINE PATIENT AFFIDAVIT

All information below is required in order to determine possible insurance coverage for a replacement machine. The machine presented today must be the most recent machine received and must be owned by the patient seeking replacement.

Original Set Up Date With Current Machine: _____/_____/_____

Current Machine Information:

Make: _____ Model: _____

Serial #: _____

- ☐ My current machine is broken.
- ☐ My current machine is obsolete and/or unrepairable.
- ☐ I no longer posses my machine.
- ☐ My doctor has ordered a replacement machine for continued effective treatment of apnea.

I certify the information presented above is true and correct. I understand I will be held financially responsible for any amount denied by my insurance due to false or misrepresented information provided.

Patient Name (Print): _____ **DOB:** ____/____/_____

Signature: _____ **Date:** _____

PCC Signature: _____

CHAP Community Health Accreditation Partner