PEAKS & PLAINS, INC.
6326 E. TRENT AVE. STE. A
SPOKANE VALLEY, WA 99212-1220

Resident Update

~ INSURANCE ~

Phone 800-585-4201
Fax 1-800-886-1747

NAME_____M___F___Date of Birth_____

FACILITY _____TYPE_____

ADDRESS_____
Street City State Zipcode

FACILITY
CONTACT NAME_____Tel_____Fax_____

PRIMARY PHYSICIAN_____Tel_____Fax_____

ADDRESS_____
Street City State Zipcode

To comply with insurers regulations, all information indicated is required. A copy of the clients Medicaid coupon must accompany this order. The above named patient requires these items for medical purposes.

I, the undersigned, hereby attest that the above person is covered by the Medicaid Program and if there is any change in coverage, I will notify Peaks & Plains, Inc. immediately. **I will be responsible for charges incurred from not providing such notification.**

I authorize Peaks & Plains, Inc. to obtain and release my medical and other information necessary in order to process my claims(s). Also, I acknowledge that I have received a copy of the Notice of Privacy Practices, which provides a description of uses and disclosures of protected health information; the Supplier Standards, which inform you of the regulations regarding covered supplies; the Client Bill of Rights and the Protocol for Resolving Complaints.

_____ _____ _____
Signature of Patient or Person Authorized to Sign for Patient DATE Sales Person
Must have POA or Authority in Writing to Sign on Behalf of the Patient.

REASON PATIENT IS UNABLE TO SIGN_____

Medicaid #_____ Medicare #_____Other Insurance_____

POA or Person Paying the Bills (if applicable)_____Tel_____

ADDRESS_____
Street City State Zipcode

Please provide patient's ***Height:_____*** ***Weight:_____***

ITEM	DESCRIPTION/SIZE	Per Day	Month