PEAKS & PLAINS MEDICAL, INC.

Fax to: 1-800-886-1747

Phone : 1-800-585-4201

New Resident

INSURANCE

Name:	**Birthdate:**	**Male: Female:**
Facility Name		**Type:**
Address:	**City**	**State & Zip code**
Telephone	**Cell Phone**	**Height: Weight:**
Facility Contact Name:	**Telephone:**	**Fax:**
Primary Physician	**Telephone:**	**Fax:**
Address:	**City**	**State & Zip code**
Email address for shipment Confirmation:		

To comply with insurers regulations, all information indicated is required. A copy of the client's Insurance card(s) 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 insurance 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/or other information necessary in order to process my claims(s) and verify eligibility for coverage of item(s) supplied. 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.

X_____ _____ _____

Signature of Patient or Person Authorized to Sign for Patient Date Salesperson

_____ _____ _____

DATE Sales Person

Print Name of Patient or Person Signing Above ***Date*** ***Relationship to Client/Resident***

(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 Billing Address:	**City**	**State & Zipcode:**

ITEM	PRODUCT DESCRIPTION/SIZE	Per Day	Month
** DOES THIS	CUSTOMER HAVE A LATEX ALLERGY? YES	NO (PLEASE	CIRCLE)