

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