Lehan's

Pharmacy | Home Medical Equipment | Women's Health

PAP SUPPLY TRANSFER FORM FOR NEW PATIENTS

Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ ST: _____ Zip: _____ Email: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

- What doctor do you currently see for your PAP device?:_____
- What is the name of your current supplier?: _____
- What is the approximate date your current device was given to you? _____
- When was the last time you received supplies?:_____
- Tell us about your equipment:
    - Make/Model of PAP device:_____
    - Type of Mask:_____
    - Size of Mask:_____
    - Type of tubing:_____

Comments:_____

_____

_____

_____

For Staff Use:

- ❑ Have copy of insurance cards and ID
- ❑ Release of Medical Records Form
- ❑ Items we still need to dispense supplies:
    - Prescription
    - PAR (if needed)
    - Sleep study
    - Current F2F showing patient using and benefitting
    - F2F prior to PSG
    - F2F showing compliance
    - Other:_____

Authorization to Release Medical Information

I authorize the named health care provider(s) to release the information or records specified to **Lehan Drugs, Inc.** upon request to the fax number or address provided at the time of request.

Patient: _____ SS#:_____ DOB: _____	Providers/Facilities: _____ _____ _____

Records Authorized to be Released:

○ History and physical ○ Discharge summary ○ Complete hospital chart ○ Office notes ○ Outpatient records ○ Physical therapy notes	○ Lab reports ○ Sleep Studies ○ Consultation notes or reports ○ Radiological Images ○ Other: _____

This information will be used to verify that the patient qualifies for services provided and will be disclosed to the patient's insurance company for their review for the coverage of services provided.

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care providers listed or to Lehan Drugs, Inc., but that revoking this authorization will not affect disclosures made or action taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization, but not doing so may result in my insurance not covering items provided to me.
- Lehan Drugs, Inc. will be able to redisclose the information provided to my insurance company.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____

Patient/Representative Signature Date

_____

Name of Representative (Print) Relationship