Alpine HOME MEDICAL

# Resupply Autoship Form

Account #:_____

Name:_____

## Qualifying Insurances:

- ☐ Aetna (040, 185)
- ☐ Altius Health Plans
- ☐ Blue Cross Blue Shield (618, 634)
  **Excludes* plans with ID prefix: CWJ, DNM, EMR, KMS, KYI, LWE, MNK, NHM, OPG, PPA, PXH, RXG, SRQ, WEX, WLQ, WNC
- ☐ Blue Cross Federal
- ☐ Blue Cross of Idaho
- ☐ Blue Cross True-Blue Idaho
- ☐ Federal Blue Cross of Idaho
- ☐ Regence Blue Shield of Idaho
- ☐ DMBA

Your PRIMARY insurance qualifies you for Alpine Home Medical's automatic PAP supply replenishment program, known as "**AUTOSHIP**." By signing up for this program, you will **automatically and conveniently receive your kit of supplies every 90 days per your insurance guidelines.**

- **1 MASK** every 3 months (headgear will come every 6 months)
  - **3 FF CUSHIONS** every 3 months (size _____), or
  - **6 NASAL CUSHIONS** every 3 months (size _____), or
  - **6 PILLOWS** every 3 months (size _____)
- **1 TUBING** every 3 months
  (_____standard, _____slim line, _____heated, or _____oxygen bleed-in)
- **6 Disposable FILTERS** every 3 months
- **1 Non-disposable FILTER** every 6 months
- **1 HUMIDIFIER CHAMBER** every 6 months (machine make/model _____)
- **1 CHINSTRAP** every 6 months (if applicable)

☐ Yes, please enroll me in the ALPINE AUTOSHIP RESUPPLY PROGRAM. By checking the box and signing below, you are authorizing Alpine Home Medical to ship your PAP supplies above. I acknowledge that I will be financially responsible for any deductibles, **co-payments** or other amounts not reimbursed to Alpine Home Medical by my insurance company or fiscal agent.

☐ I have a credit card on file for my autoship co-pay, due at the time of shipment date.

_____ _____

Patient or Authorized Representative Signature | Date

_____ _____

Therapist or Technician Signature | Date

Rev: 5/2023