

Patient Enrollment Form

Please Note: The following forms can be completed through your PDF viewer using our fillable PDF forms. Simply click your cursor on any of the lines below to fill in the form directly on your computer. **PLEASE REMEMBER TO SAVE** the completed files to your computer. These forms can also be printed and completed by hand. After completing this form, send it via email, fax or mail to Bill My Health Insurance.

Last Name: _____ First Name: _____ MI: _____

Date of birth: _____ Contact Number: _____

Email Address: _____

Current Address: _____

Are you currently using a CPAP or BiPAP? Yes / No Make and model of machine? _____

What equipment do you currently need? _____

If you currently need a replacement machine, please tell us the reason a replacement is necessary: _____

Patients with Medicare

Did you receive your current machine through Medicare? _____

Is your current machine being rented for you by Medicare? _____

Have you been receiving your supplies through Medicare? _____

Patients with Private Insurance

Did you receive your current machine through this coverage? _____

How long have you had your current machine? _____

Have you been receiving your supplies through this coverage? _____

Primary Insurance Coverage

Company Name: _____ Policy #: _____

Name of person insured: _____ Group #: _____

Date of Birth of insured: _____ Ins Phone #: _____

Insurance Address: _____

Patient Enrollment Form - cont.

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Patient Name: _____

Secondary Insurance Coverage:

Company Name: _____ Policy #: _____

Name of person insured: _____ Group #: _____

Date of Birth of insured: _____ Ins Phone #: _____

Insurance Address: _____

Other Information:

Sleep Therapy Physician Name, Address, Phone and Fax #: _____

Additional Patient Comments/Questions: _____

How did you find our site, billmyhealthinsurance.com? _____

After completion of this form, please return it to Manor Respiratory Care, Inc. via:

- 1) Fax – (804)595-0619
- 2) US Mail – 12730 Spectrim Lane, Ste H
Midlothian, VA 23112, OR
- 3) Email – info@billmyhealthinsurance.com, or use the email submit button located at the bottom of this page (Please remember to save these files for your records).

DON'T FORGET: When returning these forms, please include a copy of your **Sleep Study (both Diagnostic and Titration Report)** and your **Letter of Medical Necessity OR current prescription**.