Chino Medical Supply
12422 Central Ave
Chino, CA 91710
Ph: 909-464-1500
Fax:909-464-1570

INVOICE

SALESPERSON	ACCN #	CUST. PHONE #	ORDER DATE	DELIVERY DATE
	HEALTH NET			

SHIP TO	RESPONSIBLE PARTY
Eliel Aguilera CA	
INSURANCE INFORMATION	**DOCTOR**
ID:	CA

MANUF.	ITEM/LOT#	DESCRIPTION	BILLING CODE	QTY	UNIT PRICE	EXT.	PT. COPAY @ 20%
							0
							0
							0
							0
							0
							0
			SALES TAX				
			TOTAL	0	0	0	0

Medicare or my insurance has not purchased or rented same or similar items stated above._____ (initials)

DELIVERY TIME: _____
DELIVERY TECH: _____

__Delivery ___Pickup Contact Made_____

___ I HAVE READ THE RIGHTS & RESPONSIBILITIES AND AGREE TO ABIDE BY THEM.
___ Basic home safety assessment performed, client informed of real or potential hazards_____DT initials. List hazards discovered above in comments section.
___ Electrical ground check performed ____DT Initials ___Ground OK ___ Improper Ground * Please refer to instructions on back regarding proper electrical grounding.

Please notify of any shortage or discrepancies within 3(three) days of receipt of goods or no credit will be allowed. MERCHANDISE CONTAINED IN THIS SHIPMENT HAS BEEN CAREFULLY COUNTED AND CHECKED. PLEASE CALL OR WRITE REFERRING TO YOUR ACCOUNT NUMBER IN THE EVENT OF ANY DISCREPANCIES. THANK YOU!

I ACKNOWLEDGE RECEIPT OF EQUIPMENT AND/OR SUPPLIES LISTED ON THIS ORDER, AND ALSO I ACKNOWLEDGE THAT I HAVE BEEN FULLY TRAINED ON EQUIPMENT.

Authorization to Assign Benefits to Provider & Release or Medical Information: I request that payment of authorized Medicare, Medicaid, or other private insurance benefits be paid directly to the above named company for any services furnished me by that supplier. I further authorize a copy of this agreement to be used in place of the original and I authorize any holder of medical information about me to release to the CMS and Accreditation Company and its agents, any information needed to determine these benefits or the benefits payable to related services. Thank You!

_____	_____	_____	_____
ATTENDANT SIGNATURE (If patient is unable to sign)	RELATIONSHIP	DATE	CUSTOMER SIGNATURE