ADVANCED MEDICAL SUPPLY, INC.

3322 N Milwaukee Avenue, Chicago, IL 60641
Phone: 773-205-6993 Fax: 773-205-6994

DELIVERY TICKET

PATIENT NAME: Pajda, Kazimierz			**DATE:** 07-23-25
ADDRESS: 6460 W Belle Plaine Ave Apt 309 Chicago, IL 60634			
PHONE #: 773-545-1338 Maria 708-699-4957 Krystyna (caregiver)			
REQUEST FOR REFILLS:			**DATE:**
Quantity delivered	**Description**	**CPT code**	**Quantity ordered**
	Diapers L	T4523	200
	Diapers XL	T4524	200
	Liners ultimate	T4535	120
	Underpads	T4541	150
	Gloves L	A4927	200

I hereby request that payment of authorized insurance benefits be made on my behalf to Advanced Medical Supply, Inc. for equipment and/or services furnished to me by the aforementioned supplier. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services, health insurances or their agents any information needed to determine these benefits.

SIGNATURE OF PATIENT: _____

SIGNATURE (if other than patient): Krystyna Sadowska **RELATIONSHIP:** carg.

COMPANY REPRESENTATIVE: _____