DELIVERY RECEIPT

American HomeCare Equipment
Oxygen Permit #327067

American Homecare Equipment, Inc.
6600 NW 12th Ave
Suite 217
Fort Lauderdale, FL 33309
954-772-5052

Branch: American Homecare Equipment, Inc
Inv Location: MIAMI WAREHOUSE
Date
CSR
Order #
Patient ID
Customer #
Account #
DOB
Gender: Female **Ht (in):** 59.84 **Wt (lb):** 120.20

Bill To:

Shipped/Delivered To:

Phone:
Mobile:

Insurance: CIGNA GOVERNMENT SERVICES / AARP

HIPAA Signature on file: Yes

Comments or Special instructions:
MM - RT NEW HOME SET UP
*HCMG CLINIC
*COMPLIANCE REQUIRED

RX APAP 5-20 CM H20 WITH MASK OF CHOICE FROM DR FRANK SORHAGE

"I authorize credit card ending in 1008 to be charged for current and future insurance out of the pocket responsibilities."

Ord Qty	Del Qty	Type	Item	Ext. Allow	Ext. Amt.	Tax	Co-Pay
1	1	Rental	CP0100/GENERIC CPAP STANDARD OR AUTO 39000 / RESMED CPAP AIRSENSE 11 AUTOSET ResMed / 39000 UOM:Each(es) Serial Number: 23223608894 Note:	$63.08	$152.50	$0.00	$0.00
1	1	Purchase	E0562/HUMIDIFIER HEATED USED W PAP UOM:Each(es) Note:	$206.32	$330.30	$0.00	$0.00
1	1	Purchase	MASK-FF-NP-NA GENE/GENERIC CPAP MASK FULL FACE, NASAL PILLOW OR NASAL VIT1SMLA / (AHC ONLY) Fisher and Paykel Vitera FF Fitpack Fisher & Paykel Healthcare / VIT1SMLA UOM:Each(es) Note:	$0.00	$0.00	$0.00	$0.00
1	1	Purchase	AHC-CPAP CUSHION REP/FULL FACE, NASAL PILLOW OR NASAL CUSHION INCLUDED UOM:Each(es) Note:	$0.00	$0.00	$0.00	$0.00

Ord Qty	Del Qty	Type	Item	Ext. Allow	Ext. Amt.	Tax	Co-Pay
1	1	Purchase	A7035/POS AIRWAY PRESS HEADGEAR INCLUDED UOM:Each(es) Note:	$25.74	$50.00	$0.00	$0.00
6	6	Purchase	FIL-GEN CPAP DISPFIL/GENERIC CPAP DISPOSABLE FILTER 39301 / Air11 Filter Standard, 2 Pack ResMed / 39303 UOM:Each(es) Note:	$19.50	$54.00	$0.00	$0.00
1	1	Purchase	A7037-SLIM-AHC/AHC PAP SLIMLINE TUBING UOM:Each(es) Note:	$21.20	$75.00	$0.00	$0.00
			Total	**$335.84**	**$661.80**	**$0.00**	**$0.00**

PLEASE NOTE THAT THE ABOVE PRICING AMOUNTS ARE AN ESTIMATE OF YOUR FINANCIAL RESPONSIBILITY ONLY AND ARE NOT A GUARANTEE. FINAL DETERMINATATION OF YOUR FINANCIAL RESPONSIBILITY IS MADE BY YOUR INSURANCE PROVIDER AFTER YOUR CLAIM FOR SERVICES HAS BEEN SUBMITTED. ANY PRIVATE PAY OR OTHERWISE PATIENT RESPONSIBILITY EQUIPMENT SALES, SERVICES, OR COPAYS/COINSURANCE ARE CONSIDERED FINAL AND NON-REFUNADABLE, UNLESS AGREED TO SEPERATELY IN WRITING.

ALL INFORMATION HAS BEEN GIVEN TO THE COMPANY TO BILL ANY RESOURCES FOR SERVICES PROVIDED. I CERTIFY THIS INFORMATION IS CORRECT. I HAVE BEEN INSTRUCTED & UNDERSTAND THE SAFE USE & MAINTENANCE OF THE ABOVE EQUIPMENT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED SUPPLIER FOR SERVICES. I HAVE READ & UNDERSTAND THE PROVISIONS ON THIS AGREEMENT.

5/4/23

HML

Signature of Patient or Authorized Representative | ***Date*** | ***Tech Signature***

05/04/2023 19:00

Humberto Landa

Relationship to Patient: Self

Reason patient could not sign: