SUPPLY REPLENISHMENT ATTESTATION FORM

Core Care TECHNOLOGIES, INC.

PATIENT NAME _____

CHART No. _____ DOB _____

ID _____

INSTRUCTIONS

Medicare and some insurances have policies in place that require a reason for replacement of disposable supplies such as CPAP supplies. Please complete this form and sign in the designated area at the bottom of the form. If you have questions about how to fill out this form or need additional information, please call 856-629-0400 and ask for Customer Service.

CPAP MASK

- ☐ My mask leaks despite adjustment
- ☐ My mask is uncomfortable or no longer fits
- ☐ My mask causes skin irritation
- ☐ My mask has an odor

HEAD GEAR

- ☐ The velcro on my head gear no longer sticks
- ☐ My head gear is stretched
- ☐ My head gear is soiled

CPAP TUBING

- ☐ My CPAP tubing has a hole or is discolored
- ☐ My CPAP end rubber is worn
- ☐ My CPAP tubing has an odor.

FILTERS

- ☐ My disposable filters are dirty and need replacement
- ☐ My reusable filters are brittle, frail or no longer fit properly in the designated space.

Attestation:
The items slected above are true and accurate to the best of my knowledge.

☐ I am using my supplies as directed by my Doctor and are faithfully requesting that these supplies be replaced.

Signature of Company Representative_____ Date _____

Signature of Patient _____ Date _____