



Liability Acknowledgement Form for Anthem Members

In regards to Positive Airway Pressure (PAP) Equipment and Related Supplies

Patient Name: _____ ACIS ID/CPU: _____

Notice of Possible Non-Coverage and Patient Liability for Positive Airway Pressure (PAP) Charges Due to Insurance Company Requirements

Your insurer’s sleep therapy management program for your positive airway pressure (PAP) device and related equipment (to be used on an ongoing basis), as well as related supplies (to be ordered by you as needed), requires that you (the patient) demonstrate continued usage of your device on a periodic basis. During your first year of use, you must be able to document ongoing usage of or continued therapeutic benefit from your PAP device every ninety days. Thereafter, compliance must be documented once each year. You will be provided with instructions on how to document your usage or continued therapeutic benefit, but, unless you have received contrary instructions from your physician, you are required to consistently use the device four hours per night or more on at least 70% of nights. Failure to comply with the requirements means that your insurer may refuse to authorize (or pay for) further treatment and may classify your PAP therapy as not medically necessary. If that occurs you will become financially responsible for ongoing rental charges and the cost of related equipment and supplies at the rates reflected in the Sales Service and Rental Agreement (“SSRA”) executed in connection with this delivery and the documents accompanying future shipments of PAP supplies or equipment. Your signature on this document will signify your agreement, as more fully reflected in your SSRA, to retain the equipment and be financially responsible for the cost of your equipment and related supplies in the event your insurance carrier should deny authorization or payment for further coverage due to your failure to document continued benefit, usage or compliance as required. Your financial responsibility for the equipment will continue until it is returned to the company, and your responsibility for supplies you order can be avoided only by returning them to the company in an unopened and unused condition within ten days after you receive them.

Signing below, means that you have received and understand this notice.

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| Patient or Parent/Guardian/Agent) Signature: | Date: |
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