

**MEDICARE BENEFICIARY STATEMENT:  
Evaluation of Respiratory Assist Device**

Beneficiary Name: \_\_\_\_\_ Beneficiary Birth Date: \_\_ / \_\_ / \_\_

Beneficiary Telephone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

The Supplier May Not Answer Any Of The Following Questions.

1. Are you (the Medicare beneficiary) now using a machine that helps you take your breaths while you are asleep (separate from a machine that may be giving you oxygen or medicine)?

YES  NO

2. How many hours a day do you usually use this machine?

\_\_\_\_\_ HOURS

3. How many months have you been using this machine?

\_\_\_\_\_ MONTHS

4. Will you keep using this treatment in the future?

YES  NO

5. Did you (the Medicare Beneficiary) complete answers #1 – 5?

YES  NO

If you did not answer these questions, who did and what is their relationship to you (for example, wife, husband, supplier of machine, etc.)?

Name (Print): \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Beneficiary signature

\_\_\_\_\_  
Date of signature