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