MECHANDISE/DELIVERY RECEIPT

DATE: _____

NAME: _____

DOB: _____ **ACCOUNT #** _____

ADDRESS: _____

PHONE: _____

ABN on File YES ( ) NO ( ) UNASSIGNED ( )

MEDICAL SUPPLY: UPS USPS WALK IN
DELIVERED RETURNED

EQUIPMENT: PICK UP DELIVERED RETURNED
MONTHLY RENTAL

PRODUCT#	**DESCRIPTION**	**QTY**	**CODE**

NOTES: _____

BY SIGNING THIS, I FULLY UNDERSTAND THAT IF I AM PRESENTLY RECEIVING HOME HEALTH OR HOSPICE SERVICES, MY INSURANCE MAY NOT COVER THESE ITEMS AND I MAY BE RESPONSIBLE FOR THE CHARGES. I ALSO UNDERSTAND THAT EVEN THOUGH I HAVE A PRESCRIPTION FROM A PHYSICIAN, IT IS NOT NECESSARILY A GUARANTEE THAT THIS WILL BE COVERED OR PAID BY MY INSURANCE PLAN(S) **INITIAL**_____.

_____ _____
Customer Signature OR Responsible Party **Date**

_____ _____
Tri-County Medical Associate Revised 01/10 **Date**