PURCHASE/RENTAL PRICING FOR HME

Patient Name:

Insurance Plan:

Date of Birth:

Policy Number:

Total Estimated Charges:		$0.00
Deductible	$	-
Co-Insurance		$0.00
Total Estimated Patient Amount:		**$0.00**

Deductible:		
Deductible Met:	$	-
Out Of Pocket:		
Out Of Pocket Met:	$	-
Co-insurance:		

Definitions:

Deductible: The amount you have to pay each year before your plan starts paying benefits.

Out Of Pocket: The amount your insurance company requires you to pay before you are no longer subject to co-insurance.

Co-Insurance: The percentage of the amount covered that your insurance requires you to pay.

Total Estimated Charges: The estimated charge(s) for the services provided.

Total Estimated Patient Amount: The amount you will be responsible for paying:

CODE	ITEM DESCRIPTION	CHARGED AMOUNT		RENTAL COST	UNITS BILLED	FREQUENCY	RENTAL COST BILLED TO INSURANCE
E0601	CPAP Unit	$ 223.00	RR	$95.77		PER MONTH FOR 10 MONTHS	$0.00
E0470	BiPAP without backup rate feature	$ 423.00	RR	$181.89		PER MONTH FOR 10 MONTHS	$0.00
E0471	BiPAP with backup rate feature	$ 1,051.00	RR	$327.68		PER MONTH FOR 10 MONTHS	$0.00
E0562	Heated Humidifier	$ 497.00	NU	$285.48		Insurance May Purchase Or Rent	$0.00
A4604	Tubing with integrated heating element- (1 Per 3 Months)	$ 129.00	NU	$55.47			$0.00
A7030	Full face mask-(1 Per 3 Months)	$ 311.00	NU	$133.73			$0.00
A7031	Face Mask Cushion- (1 per 3 Months)	$ 121.00	NU	$41.65			$0.00
A7032	Cushion On Nasal Mask-(2 Per Month)	$ 70.00	NU	$46.58			$0.00
A7033	Nasal Pillow Replacement-(2 Per Month)	$ 49.00	NU	$38.57			$0.00
A7034	Nasal interface mask or cannula-(1 Per 3 Months)	$ 204.00	NU	$114.99			$0.00
A7035	Headgear-(1 per 6 Months)	$ 66.00	NU	$38.17			$0.00
A7036	Chin strap-(1 per 6 Months)	$ 36.00	NU	$13.01			$0.00
A7037	Hoses/Tubing-Standard (1 Per 3 Months)	$ 70.00	NU	$30.81			$0.00
A7038	Filter, disposable used with CPAP-(2 Per Month)	$ 9.00	NU	$4.35			$0.00
A7046	Humidifier Chamber-Replacement-(1 per 6 Months)	$ 34.00	NU	$24.43			$0.00

We are pleased that you have chosen Unity Health Network Home Medical Equipment (HME) for your healthcare services. Please be aware that this ESTIMATE may change due to changes in pricing or in your insurance coverage. Please contact us to update this ESTIMATE as needed. The above costs associated with your visit are an ESTIMATE of your portion of the balance, based on your insurance benefits at time of service. Please remember that the contract with your insurance company is ulitimately your resposibility. We honor any contracts we may have with them; however, you are responsible for your deductible, co-payments, and/or co-insurance. These benefits are only an ESTIMATE of coverage and not a guarantee of payment. For any questions call (330) 572-1011 x 177.

Patient Signature: _____ Date: _____