

InfaScan Diagnostic Services

Apnea Monitor Data Management Program

e-mail : download@infascan.com

Patient Enrollment

DATE _____

PATIENT INFORMATION

| | | | |
|---------------------------|-------|------------|-------|
| Last Name | _____ | | |
| First Name | _____ | | |
| MI | _____ | | |
| DOB | _____ | Gestation: | _____ |
| Address | _____ | | |
| City | _____ | | |
| State | _____ | | |
| Zip Code | _____ | | |
| Child's Social Security # | _____ | | |
| (Area Code) Phone # | _____ | | |

PHYSICIAN INFORMATION

Prescribing

Attending

| | | |
|-------------------------------|--|--|
| Physician's Name | | |
| Address | | |
| City, State, Zip Code | | |
| (Area Code) Phone # | | |
| (Area Code) FAX # | | |
| UPIN # | | |
| e-mail Address | | |
| Clinic Name (if applicable) | | |
| Clinic Access/Medicaid # | | |
| Send copy of download report? | | |

INSURANCE INFORMATION

Primary

Secondary

| | | |
|--------------------------------|--|--|
| Insurance Company | | |
| Address | | |
| City, State, Zip Code | | |
| Ins. Co. Authorization Phone # | | |
| Ins. Co. Contact Name | | |
| Policy # | | |
| Policy Holder's Name | | |
| Policy Holder's SSN | | |
| Policy Holder's DOB | | |
| Group Name | | |
| Group # | | |

** Shaded areas are to be completed when applicable.

FOR INTERNAL USE ONLY

| | |
|-------------------------------|-------|
| Insurance Pre-authorization # | _____ |
| Comments | _____ |
| HME Dealer | 0 |
| 1st download received | _____ |
| ADMP entry date | _____ |
| Monitor D/C date | _____ |

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