

**INFASCAN DIAGNOSTIC SERVICES  
APNEA MONITOR DATA MANAGEMENT PROGRAM  
DEALER SERVICES AGREEMENT**

DEALER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

MONITOR BRAND/MODEL: \_\_\_\_\_

HOW WILL DATA BE SENT? \_\_\_\_\_

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**RESPONSIBILITIES OF HOMECARE DEALER:**

- \*RETRIEVAL OF WAVEFORM DATA FROM PATIENT'S HOME AND DELIVERY OF THE DATA TO INFASCAN
- \*COMPLETION OF THE DATA INPUT SHEET
- \*COMPLETION OF THE CLINICAL INFORMATION FORM
- \*COMPLETION OF ASSIGNMENT OF BENEFITS FORM WITH SIGNATURE
- \*RETURN FREIGHT IF APNEA MONITOR IS SENT TO INFASCAN
- \*COPY OF THE PATIENT'S INSURANCE CARD

**RESPONSIBILITIES OF INFASCAN DIAGNOSTIC SERVICES:**

- \*RECEIPT, DOWNLOADING AND REVIEW OF EVENT DATA
- \*FORWARD DATA TO INTERPRETING PHYSICIAN FOR INTERPRETATION AND RECOMMENDATION
- \*INSURANCE AUTHORIZATION FROM PATIENT'S INSURANCE COMPANY FOR THIS SERVICE

**I UNDERSTAND AND AGREE TO THE ABOVE STATED RESPONSIBILITIES AND THAT THE APPROPRIATE PAPERWORK MUST BE COMPLETED IN ORDER TO PROCESS THE WAVEFORM MONITOR REPORT. I FURTHER UNDERSTAND THAT ANY MONITOR DATA THAT DOES NOT INCLUDE THE REQUIRED PAPER WORK THOROUGHLY AND CORRECTLY WILL NOT BE PROCESSED. I UNDERSTAND THAT INFASCAN WILL NOTIFY ME OF ANY INCOMPLETIONS VIA FAX AND THAT THE DATA WILL BE HELD FOR 30 DAYS PENDING RECEIPT OF COMPLETED DOCUMENTS BEFORE BEING RETURNED TO THE ME. I FURTHER UNDERSTAND THAT IF FOR ANY REASON THE INSURANCE PRE-AUTHORIZATION IS DENIED THAT I HAVE THE CHOICE OF PAYING THE SERVICES FEES OR REMOVING THE PATIENT FROM THE PROGRAM.**

DEALER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

INFASCAN DIAGNOSTIC SERVICES by \_\_\_\_\_ DATE \_\_\_\_\_