ENTERAL NUTRITION THERAPY

Opt-In Enteral Refill Program Enrollment Form

Dear Valued Patient:

In order to help you receive effective enteral therapy and maintain adequate compliance, Apria Healthcare ("Apria") is pleased to offer you the opportunity to participate in the Opt-In Enteral Refill Program. This program offers you the convenience of receiving your enteral formula and supplies on an ongoing monthly basis without your having to initiate the order. Your formula and supplies will be sent directly to you on a monthly basis with no additional shipping or handling fees! Please note that Medicaid, Medicare, TRICARE, managed Medicare, and managed Medicaid patients are not able to participate in Apria's Opt-In Enteral Refill Program.

Please ship my eligible enteral refill supplies monthly:

☐ **Pump** ☐ **Gravity** ☐ **Bolus**

The following supplies will be included:

- Formula
- Syringes
- Feeding bags
- Gauze
- Tape
- Extension sets

**See the accompanying refill quantities that are allowed by most insurance plans. Please note that the supplies actually included in your refill delivery will be governed by your insurance plan, and may be different than those listed on the refill supply list described below. Also be aware that refill quantities are subject to change based upon physician orders, patient medical condition, and the discretion of your insurance company. Patients who wish to order supplies more frequently or to order different supplies may contact their local Apria office.*

Please note: Your order may arrive in separate packages and on different days as parts of it may be shipped from multiple warehouses depending on stock availability.

With my signature I authorize Apria to send me my enteral refill shipments each month. I understand that I am responsible for any portion of the cost not covered by my insurance plan, including applicable coinsurance and deductibles, and that I must communicate any changes in my insurance coverage to Apria as soon as possible. Apria requires a credit card to be on file for regular supply shipment. I further understand that this Opt-In program is not available to patients with certain insurance.

Patient name ______________________ Daytime phone ______________________

Insurance ID # ______________________ E-mail address ______________________

Physician/representative signature______________________ Relationship to patient ______________________

Date ______________

You may cancel your Opt-In enrollment at any time by calling (844) 260-1788 in the Continental U.S. or (800) 454-5672 in Hawaii.

For your convenience, this form may also be completed online to begin your refill process. Please visit **Apria.com/enteral**.

Fax completed form to the Enteral Team at:
(844) 281-1311

Or mail to:
6050 Sprint Pkwy, 3rd Floor
Overland Park, KS 66211

PLEASE PROVIDE A COPY OF THIS FORM TO THE PATIENT

REFILL SUPPLY LIST

Description	Refill Allowance
Formula	As prescribed
Syringes — Syringe feeding	30 per month
Syringes — Gravity/pump feeding	4 per month
Feeding bags	30 per month
Gauze	1 box per month
Tape	1 roll per month
Extension sets	4 per month
Replacement G-tube	1 per 3 months
Replacement NG-tube	1 per month

APRIA use only ACIS BU ______________ ACIS customer ID ______________ Credit card is required for this program

If there is more than one CC on file in ACIS, please specify which one to use ______________________

Branch contact name and phone ______________________

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