025-NP
(rev. 12/03)

Non-Prescription
Medical Expense Verification

To: ________________________________ Return to: ________________________________

________________________________ ________________________________

________________________________ ________________________________

Phone: ________________________________ Phone: ________________________________

Fax: ________________________________ Fax: ________________________________

I have applied or I am currently a resident at the above noted Apartment Community. It is of benefit to me to disclose and verify my medical expenses and all other reasonable, anticipated medical expenses for the next twelve months.

I understand I have signed a HIPPA release in your office and if I have failed to disclose my apartment community as an authorized recipient of the requested information, then I give you that permission at this time and would appreciate your cooperation in providing any medical expense information to the above noted address.

____
Signature

________________________________ ________________________________ ________________________________
Printed Name Social Security Number Date of Birth

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The above disclosed has stated that you have recommended the following list of non-prescription items. Please check yes or no if you have recommended this item.

1. ______________________________________ Yes ____ No ____
2. ______________________________________ Yes ____ No ____
3. ______________________________________ Yes ____ No ____
4. ______________________________________ Yes ____ No ____
5. ______________________________________ Yes ____ No ____

Signature: ________________________________ Title: ________________________________

Printed Name: ________________________________ Date: ________________________________

Phone #: ________________________________ Fax #: ________________________________

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Note: If this is a HUD Financed property Individual Consent Authorization (FAM form #H004B) must be attached.