CPAP SUPPLIES PRESCRIPTION
VALID 1 year
***IF NOT OWNED BY PATIENT PLEASE CONVERT TO A PURCHASE AS SOON AS POSSIBLE.
PATIENT USES AND BENEFITS FROM MACHINE**

Name:
DOB:
Email:
Phone:
Address:
Dx: G47.33

PLEASE RENEW WITH DME: Please provide supplies (REGULAR AND HYPOALLERGENIC: 1/mo) filters etc.) replace as allowed. Replace masks, filters and tubing (HEATED) as needed and allowed. Chin straps PRN etc.

WE EXPECT SUPPLIES WITHIN 1 week.

PLEASE CONTACT Patient and see if they need a MASK FITTING AND ARRANGE IT AS NEEDED.

Supplies As allowed by insurance (I request):
Mask 1/3 months
Cushion 1/1 months
Headgear 1/6 months
Tubing 1/3 months
Disposable filter 2/1 months
Non-disposable filter 1/6 months (HYPOALLERGENIC FILTER: VERY IMPORTANT!)

GOOD FOR 1 YEAR from the date of the prescription.

Name of Provider and credentials:
NPI:
Signature:
Date: