



DURABLE MEDICAL EQUIPMENT PRESCRIPTION

PATIENT INFORMATION

Patient Name: _____ DOB: ____ / ____ / ____ Gender: M F
 Address _____ City _____ State _____ Zip: _____
 Home Phone: (____) _____ Work Phone: (____) _____
 SSN: _____ / _____ / _____ Insurance Co: _____

PHYSICIAN INFORMATION

Name: _____ TEL: (____) _____ FAX: (____) _____
 Physician UPIN #: _____ NPI #: _____

TREATMENT DEVICES/SUPPLIES

(Please Check)

- CPAP DEVICE
Pressure Setting: _____ CM H20
Mask Size/Type (If Known): _____
- BI-LEVEL DEVICE
Pressure Setting:
IPAP _____ CM H20
EPAP _____ CM H20
Mask Size/Type (If Known): _____
- HEATED HUMIDIFIER
- FULL REPLACEMENT SUPPLIES/ACCESSORIES
Length of Need _____ (99=Lifetime)
- OTHER *(Please Specify):* _____

DIAGNOSIS

(Please Check)

- OBSTRUCTIVE SLEEP APNEA
- EXCESSIVE DAYTIME SLEEPINESS
- HYPERTENSION
- PULMONARY HYPERTENSION
- CARDIAC ARRHYTHMIAS
- FATIGUE
- STROKE
- DOCUMENTED ISCHEMIC HEART DISEASE
- OTHER *(Please Specify):* _____

Physician's Signature: _____ Date: _____

PLEASE FAX THIS **SIGNED** FORM **ALONG** WITH A COPY OF THE PATIENT'S
SLEEP STUDY REPORT(S), INSURANCE CARD, AND FACE SHEET
 TO **(866) 906-8198** OR CALL US TOLL-FREE AT **(877) 7-SLEEP-7**