NextGen
Medical Supplies, Inc.

PLEASE FAX TO:
(888) 613-5719

RX FOR FULL FACE MASK

PRESCRIPTION DATE:

PT ID:

A. PATIENT INFORMATION	B. PHYSICIAN INFORMATION
Name: **Address:** **Phone:** **DOB:**	**Name:** **Address:** **NPI:** **PHONE #:** **FAX #:**

Please complete the following form:

C. DIAGNOSIS

G47.33 Sleep Apnea: Adult or Pediatric

D. LENGTH OF NEED

LIFETIME unless otherwise noted _____ Months (99=lifetime)

E. SUPPLIES

The following dispensable equipment is necessary for the proper use of the PAP equipment and is not part of the CPAP, Bi-level, or AVAP machine when purchased or rented. I prescribe the following equipment unless otherwise specified. I have **crossed off** any items I do **not** wish to prescribe.

FULL FACE MASK (A7030:1/3M) **with Full Face Mask Cushion** (A7031:3/3M)

Tubing (A7037:1/3M) **Tubing with intergrated heating** (A4604:1/3M) **Disposable Filter** (A7038:6/3M)

Replacement Water Chamber for Humidifier (A7046:1/6M) **Chinstrap** (A7036:1/6M)

Non-Disposable Filter (A7039:1/6M) **Other:**_____

Headgear (A7035:1/6M)

F. SIGNATURE & DATE - By signing below, I confirm the medical supplies and/or medication herein are medically necessary and that this prescription is valid for NextGen Medical Supplies Inc. I have had a face-to-face encounter with this patient within the last 6 months and have documented the condition related to this order in their medical record. I will furnish substantiating medical records upon request.

Step 1

Physician Signature: _____ **Date:** _____/_____/_____

Printed name and NPI required of signing physician if different from provider printed above

Printed Name: _____ **NPI:** _____

Start Date (equal to signature date unless otherwise specified):_____

Contact Us
Customer Service: (888) 557-7085
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