NextGen
Medical Supplies, Inc.

PLEASE FAX TO:
(888) 613-5719

RX FOR PAP THERAPY

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. MACHINE TYPE – Must be indicated

☐ **CPAP or APAP (E0601) with Heated Humidifier (E0562) unless otherwise specified**

Pressure or Range _____-_____ CM/H2O

☐ **BiPAP / Bi-level (E0470) with Heated Humidifier (E0562) unless otherwise specified**

Pressure or Range _____/_____ CM/H2O

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.

Physician Signature: _____ Date: _____/_____/_____

Step 1

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
www.nextgenmeds.com

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