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PHYSICIAN'S PRESCRIPTION FORM

Barber D.M.E. Supply Group

"We Pride Ourself On Taking Care Of You - Body And Sole"

PROVENT®

sleep apnea therapy

FAX TO

Supplier's Name: **Barber DME Supply Group**

Supplier's Fax #: **877-262-4248**

Sender's Name:

PATIENT INFORMATION

Patient Name:	**Patient DOB:**
Address:	Daytime Phone #:
	Evening Phone #:
City: **State:** **ZIP:**	Email Address:

DIAGNOSIS & PRODUCTS (Please Select All That Apply)

Diagnosis:	**ICD-10:**

☐ **Provent Therapy 3-Phase Starter Kit** (Includes First Month's Supply)

☐ **Provent Therapy Monthly Supply** (Number of Refills: For Unlimited Refills Enter 99)

PHYSICIAN INFORMATION

Physician Name:	**UPIN #:**
Office Address:	NPI #:
	Phone #:
	Fax#

PHYSICIAN SIGNATURE: **DATE:**