

PHYSICIAN'S PRESCRIPTION FORM

Barber D.M.E. Supply Group

"We Pride Ourselves On Taking Care Of You - Body And Soul"

PROVENT[®]
sleep apnea therapy

FAX TOSupplier'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:
<input type="checkbox"/> Provent Therapy 3-Phase Starter Kit (Includes First Month's Supply)	
<input type="checkbox"/> 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:**

This fax message, and any attachments, may contain confidential information. If you are not the intended recipient and have received this message in error, please inform the sender and delete the contents without copying distributing or forwarding.