**CPAP SUPPLIES ORDER FORM**

Patient Name: / Date of Birth

Primary Insurance: Member #:

Secondary Insurance: Member #:

NON-RETURNABLE SUPPLIES

\_\_Full Face - Mask (Size, Brand, Model):

\_\_Nasal Pillows, Size:

\_\_Tubing

\_\_Headgear, size:

\_\_Chin Strap: Regular / Deluxe / Premium

\_\_Humidifier: Heated/ Cool (Brand/Serial #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Disposable Filters (6)

\_\_Non-Disposable Filters (1)

\_\_Humidifier Water chamber

EQUIPMENT PURCHASE: I understand that JAMIL SULIEMAN MD, INC will bill my insurance carrier for issuing the equipment listed above as a courtesy to me. I agree that I am financially responsible for the total cost of all equipment, and I will pay all deductibles and co-payments as indicated by my insurance carrier.

Patient/ Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_