PROVIDER PRESCRIPTION FORM

BONGO Rx

A Sleep Apnea Therapy Device

Looking for a Prescribing Physician or Supplier in your area? Visit www.AirAvant.com/for-the-patient

FAX TO

Supplier Name: The DME Source

Supplier Fax #: 248-282-9049

Sender's Name: _____

PATIENT INFORMATION

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

DIAGNOSIS & CARE PLAN

Diagnosis: ☐ Obstructive Sleep Apnea (OSA), mild to moderate
Prescribed Product: ☐ Bongo Rx (No substitutions)
Number of Refills: ☐ 99 (Unlimited Refills) ☐ Other _____

PRESCRIBER INFORMATION

Prescriber Name:	NPI#:
Office Address:	License #:
	Phone #:
	Fax #:

PRESCRIBER'S SIGNATURE: **DATE:**