PM RESPIRATORY SERVICES, INC.

BENEFICIARY'S NAME:
MEDICARE ID:
DOB:
EQUIPMENT ORDERED:

PATIENT NEEDS THE ABOVE CPAP/BIPAP SUPPLIES REPLACED. IN ORDER FOR MEDICARE TO COVER THESE ITEMS WE NEED TO HAVE A DESCRIPTION OF WHAT IS WRONG WITH THE CURRENT SUPPLIES. ***THE DESCRIPTION MUST BE LEGIBLE FOR MEDICARE TO READ. PLEASE BE AS DETAILED AS POSSIBLE. THANK YOU!***

_____ _____
BENEFICIARY'S (PRINT NAME) BENEFICIARY'S SIGNATURE

DATE:_____/_____/_____
IF THE BENEICIARY IS UNABLE TO SIGN RELATIONSHIP_____

3306 SW 26th Ave, Bldg. #400, Suite #402
(877) 237-4545 ** fax (877) 237-9655
Office Hours: 8:00am-5:00pm M-F
****24-Hour Service Provided****