



Sleep Disorders Institute, Inc. CPAP Equipment & Supplies

CPAP Supplies Request Form

Patient Name _____ Phone# _____

Ship to Address _____ New?

City _____ State _____ Zip _____

Please ship the following items and bill my insurance.

____ Mask (1 per 6 mo) Style _____ Size _____

____ Headgear (1 per 6 mo) Style _____ Size _____

____ Nasal cushions (1 per mo) Style _____ Size _____

____ Full Face Cushion (1 per mo) Style _____ Size _____

____ Chin Strap (1 per 6 mo) Style _____ Size _____

____ Disposable filters (2 per mo) CPAP Machine _____

____ Non-Disposable filters (1 per 6 mo) CPAP Machine _____

____ Humidifier chamber (1 per 6 mo) CPAP Machine _____

____ CPAP Tubing (1 per 3 mo) Slim Heated Standard

____ Misc Supplies _____

Please complete for accurate insurance billing.

Primary Insurance _____ Policy # _____ New?

Secondary Insurance _____ Policy # _____ New?

Shipped _____

Bill _____

Patient Signature _____ Date _____

I agree to pay any portion not covered by insurance.

Call Toll Free (800)403-6483 or Fax (888) 403-6483 or Email: sleepdisorders@kc.rr.com

Thank you! We appreciate your business.