PRESCRIPTION FORM

FAX PRESCRIPTION TO A STOCKING BONGO RX SUPPLIER

Supplier Name: _____

Supplier Fax #: _____

Sender's Name: _____

Check with your preferred local supplier or check this page for stocking suppliers:
www.BongoRx.com/patient-resources

(Do not send prescriptions directly to AirAvant Medical)

A Sleep Apnea Therapy Device

PATIENT INFORMATION (Required)

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:**