

Name (Print) _____

Address _____

Phone # _____

Today's Date _____

Dear Pacific Island Medical,

I, (Pt Name) _____ have a CPAP/BIPAP from

Vendor (DME Co.) _____

Issued on (Date or year) _____

**** Reason(s)** for need of replacement PAP device / supplies:

Model/Mfr _____

Serial# _____ **Device #** _____ (3-digits for Resmed only)

I am requesting replacement PAP DEVICE/ SUPPLIES from Pacific Island Medical.

Signed,

Signature Date _____

Print Name