



## Prescription

Ordering Physician _____	Physician's Address _____	Supplier Central Nebraska Home Care 221 W. 44 <sup>th</sup> Street Kearney, NE 68845-2412	Supplier Information Fax 308-865-2936 Tax I.D. 47-0692112
Phone _____	_____		
Fax _____	_____		

Patient \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Central Nebraska Home Care is requesting this prescription with authorization and at the request of the patient

Obstructive Sleep Apnea  Other Unspecified Sleep Apnea

Hypersomnia with Sleep Apnea, unspecified

Please provide patient with CPAP mask/interface/delivery system as per patient preference

Physician's Signature \_\_\_\_\_ NPI \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ License State/Number \_\_\_\_\_

**After completion, please fax to: 308-865-2936**

**If you have any questions concerning this request, please call 800-433-4416 or 308-865-2711**

\* Central Nebraska Home Care is providing these supplies as a cash transaction only – private insurance claim submission is the responsibility of the customer