Prescription Request

Please fax to 800-715-5422 or email to speechvive@sunmedmedical.com

Patient Information

Name: _____
DOB: _____
Phone: _____
Email: _____

HCPCS: K1009 – Speech volume modulation system, any type, including all components and accessories

Diagnosis Code(s):

☐ G20 – Parkinson's disease
☐ Other _____

Medical Records Required: These products require medical records to be collected, including clinical notes. Please fax them, in addition to this prescription, to the number above.

Prescriber Information (All Fields Are Required)

Prescriber Name: _____
Practice / Office Name: _____
NPI: _____
Phone: _____
Fax: _____

**I attest that this patient presents with the diagnosis(es) outlined above and the device/equipment is medically necessary and prescribed to compensate for the patient's condition.*

Prescriber's Signature: _____ **Date:** _____