Please email this demographic form to speechvive@sunmedmedical.com or fax to 800-715-5422. Please also include a completed prescription as well as supporting clinical documentation.

Patient Name (Last, First, MI): _____
DOB: _____
Patient Cell Phone #: _____
Email Address: _____
Is it okay for us to leave a message at this number/email: _____
Patient Address (Street, City, State, Zip): _____
Shipping Address (if different from patient address): _____
Gender: _____

Physician Information
Ordering Physician Name: _____
Ordering Physician NPI #: _____
Ordering Physician Phone Number: _____
Ordering Physician Fax Number: _____

Primary Insurance
Name of Insurance: _____
Policy # _____
Group# _____
Policy Holder Name: _____
Policy Holder DOB: _____
Insurance Phone # _____
Insurance Address: _____
Please provide a copy of the insurance card if you have it

Secondary Insurance
Name of Insurance: _____
Policy # _____
Group# _____
Policy Holder Name: _____
Policy Holder DOB: _____
Insurance Phone # _____
Insurance Address: _____
Please provide a copy of the insurance card if you have it

Device Preference
We recommend you wear the SpeechVive device on the ear opposite ear you hold a telephone to or on the ear that you can significantly hear better if there is a difference.
Right Ear ☐ Left Ear ☐

Prescription Request

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

Patient Information

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

HCPCS: E3000 – 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:** _____