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

☐ **Medical Records Required: Please submit supporting clinical documentation with this Rx form.**

Patient Name (Last, First, MI): _____
DOB:_____ Gender: _____
Patient Cell Phone #: _____ Email Address: _____
Is it okay for us to leave a message at this number/email: Yes No
Patient Address (Street, City, State, Zip): _____
_____
Shipping Address (if different from patient address): _____
_____

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

HCPCS: E3000 – Speech volume modulation system, any type, including all components and accessories

Diagnosis Code(s):
___ G20.A – Parkinson's disease without Dyskinesia
___ G20.B- Parkinson's disease with Dyskinesia
___ G20.C- Parkinsonism, Unspecified
___ - Other- _____

Prescriber's Information
Ordering Physician Name: _____

Ordering Physician NPI #: _____

Ordering Physician Phone Number: _____

Ordering Physician Fax Number: _____

I can 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 disorder.

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

Medical Records Required: Please submit supporting clinical documentation with this Rx form