



CPAP MASK CUSHION ORDER FORM

You may receive 2 nasal cushions/pillows or 1 full face cushion per month in addition to the new mask every 3 months.

This form is NOT for the whole mask only for the cushion/pillow.

- Send me an order of cushions upon receipt of this letter.
- I use my mask at least 4 hours every 24 hour period.
- I have used CPAP for the preceding 2 months.

Name: _____

Signature: _____

Phone: _____

Date: _____

Select Cushion Mask (circle one):

Comfort Select:	S	M		SW	
Comfort Gel:	P	S	M	L	
Optilife:	P	S	M	L	
Swift 2:		S	M	L	
Activa:	ST			L	SH
Mirage Full Face:	S	M	L		

Return to : United States Medical Supply, Inc.
8260 NW 27 ST # 401 Miami, FL 33122
1-877-876-3358 Fax: 305-403-4870

www.us-med.com/cpap.htm