



# Blue Mountain Medical

## Edmonds

7320 216<sup>th</sup> ST SW, Suite #30  
Edmonds, WA 98026  
1-425-673-3773  
1-425-673-3776 fax

## Tacoma

1530 S Union, Suite #10  
Tacoma, WA 98405  
1-253-759-2700  
1-759-9986 fax

### COMPLIANCE LETTER

DATE: / /

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone # \_\_\_\_\_ Social Security # \_\_\_\_\_

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**The Supplier may not answer any of the following questions**

- 1) Are you (the patient) now using a "CPAP or BiPAP" machine that helps you sleep at night? \_\_\_\_yes \_\_\_\_no
- 2) How many hours a day or night do you use your machine? \_\_\_\_\_ hrs
- 3) How many months have you been using your machine? \_\_\_\_\_ months/years
- 4) When did you last see the doctor that ordered this machine \_\_\_\_\_ days/months?
- 5) Will you keep using this machine in the future? \_\_\_\_yes \_\_\_\_no. If not why not? \_\_\_\_\_
- 6) Did you "the patient" complete answers 1-6? \_\_\_\_yes \_\_\_\_no

If you did not answer these questions, who did and what is their relationship to you (for example, wife, husband, domestic partner)? \_\_\_\_\_

Patient Name (print) \_\_\_\_\_

**ATTN: Signature is required!!!!**

Patient Signature: \_\_\_\_\_