RESPIRATORY/CPAP PHYSICIAN ORDER

REFERRAL AGENCY________________________________

Patient Name:____________________________________ DOB: _______________ ☐ Male ☐ Female

Address:____ Phone: ____________________

Insurance 1: ______________________ Insurance ID:____

Insurance 2:_______________________ Insurance ID:____

DIAGNOSIS CODE: ☐ Obstructive Sleep Apnea(327.23) ☐ Central Sleep Apnea(327.27) ☐ Other___________

☐ **E0601** CPAP Settings:________ cm H2O
☐ **E0601** CPAP Auto Settings: Range between _______and_______ cm H2O
☐ **E0470** Bi-Level Settings: ______IPAP _______EPAP (was CPAP tried and it failed ☐ **Yes** ☐ **No**)
☐ **E0470** Bi-Level Auto Settings: Range between _______ and _______
☐ **E0471** Bi-Level ST with Back Up Rate: _______IPAP _______EPAP _______RATE
☐ **E0471** Bi-Level SV with Back Up Rate: Settings ____
☐ **E0562** Heated Humidifier ☐ **A9900** Cool Humidifier ☐ **A7046** Water Chamber

RESPIRATORY PRESCRIPTION

☐ **A7034, A7032, A7035, A7037** (Nasal Mask, Accessories)
☐ **A7034, A7033, A7035, A7037** (Nasal Pillow mask, Accessories)
☐ **A7030, A7031, A7035, A7037** (Full Face mask, Accessories)
☐ **A7027, A7028, A7029, A7035, A7037** (Oral/Nasal, Accessories)
☐ **A7038** Disposable Filter ☐ **A7039** Non-Disposable Filter ☐ **A7036** Chinstrap ☐ **A7046** Water chamber
Mask Size: ☐XSm ☐Sm ☐ Med ☐ Lg ☐ LgWide ☐ XLg **Pillow Size**: ☐Sm ☐Med ☐Lg
Headgear size ☐Sm ☐Med ☐Lg Mfg.____________________ Mask ______________________

SaO2 Levels must be ≤ 88% on Room air to qualify ☐ **E1390** Oxygen _____ LPM Continuous
SaO2: ___________% Date of Test: _____________ _____ LPM at Night
_____ LPM Bleed into CPAP

SaO2 Levels must be ≤ 88% with Activity to quality
SaO2: ___________% Date of Test: _____________ ☐ **E0431** Oxygen _____ LPM Portable

Length of Need ☐ **12 Months** ☐ **99 (99=Lifetime)** ☐ **Mask and Equipment** ☐ **Routine Supplies as approved by Insurance**

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being.
In my opinion, the supplies are both reasonable and necessary to accepted standards of medical practice in treatment of this patient's condition and are not prescribed as convenience supplies.
By signing this form, I am confirming that the above information is accurate.

☐ There is a face-to-face evaluation that documents that the beneficiary continues to use and benefit from the PAP device

Physician Name: ____ NPI #_______________________

Address: _____________________________City:__________________ State:_______ Zip: ___________

Phone #: ________________________________ Fax #: _______________________________________

Physician Signature: _____________________________________ Date: __________________________