Dispensing Order – CPAP / Bi-Level PAP

Patient Name: (Last, First)	Address: (include Zip Code)	Order Date
_____	_____	_____/_____/_____
Primary Insurance: *Policy #:*_____	**Secondary Insurance:** *Policy #:*_____	**Date of Birth:** _____/_____/_____
Diagnosis: ❑ G47.33 Obstructive Sleep Apnea ❑ G47.31 Central Sleep Apnea ❑ Other (Specify w/code): _____		**Length of Need:** ❑ Lifetime ❑ Other: _____

CHECK APPROPRIATE BOXES TO PRESCRIBE EQUIPMENT/SUPPLIES. IF DELETING ANY SUPPLY, INDICATE AND INITIAL

Equipment:
Please review the equipment you are prescribing:

❑ E0601 CPAP Unit

❑ E0470 Bi-Level Unit

❑ E0471 Bi-Level w/back-up rate

❑ E0562 Heated Humidifier

Please review equipment you are prescribing

Mask Type: Please review one of the options below and select the mask and corresponding cushion type.

❑ **Nasal Mask A7034 (1 per 3 months)**
- ❑ **Cushion A7032 (2 per month)**

❑ **Full Face Mask A7030 (1 per 3 months)**
- ❑ **Cushion A7031 (1 per month)**

❑ **Nasal Pillows A7034 (1 per 3 months)**
- ❑ **A Cushion A7033 (2 per month)**

❑ **Full Face Mask A7030 (1 per 3 months)**
- ❑ **Oral Cushion A7028 (2 per month)**
- ❑ **Nasal Cushion A7029 (2 per month)**

Supplies: Please review one of the options below and select all needed routine supplies.

❑ A7035 Headgear (1 per 6 months)
❑ A7037 Tubing (1 per 3 months)
❑ A7038 Filter, Disposable (2 per month)
❑ A7039 Filter, Non-Disposable (1 per 6 months)
❑ A7046 Water Chamber (1 per 6 months)

Supplemental supplies as desired:

❑ A7036 Chinstrap (1 per 6 months)
❑ A4604 Tubing with heated element (1 per 3 months)

CPAP Orders:	Bi-Level Orders:	Auto Bi-Level Orders:	SV Bi-Level Orders:
CPAP Pressure: ____cm H_2O	IPAP Press: ____cm H_2O	IPAP Max: ____cm H_2O	IEPAP Range: _____
OR	EPAP Press: ____cm H_2O	EPAP Min: ____cm H_2O	EPS Min: _____ cm H_2O
AutoPAP High Press:____ cm H_2O			PS Max: _____ cm H_2O
AutoPAP Low Press: ____cm H_2O	Back-Up Rate: _____		Max Press: _____ cm H_2O
			Back-Up Rate: _____

Due to the above diagnosis, a Bi/CPAP Unit is required for this patient. I the undersigned, certify that the above prescribed equipment is reasonable and necessary according to accepted standards in the treatment of this condition and is not prescribed as a convenience device. The above name patient is at risk for heart arrhythmias, high blood pressure, and other symptoms associated with Obstructive Sleep Apnea Syndrome if s/he remains untreated. Additionally, the use of this device will improve sleep architecture resulting from OSAS, as well as long term reversal of symptoms (excessive daytime sleepiness, poor concentration, forgetfulness, irritability, anxiousness, depression, falling asleep on the job or while driving). Documentation supporting the diagnosis and need for equipment is present in the medical record and is available upon request.

Medical Justification, if this is a replacement machine:_____

Physician Signature: _____	**Date:** _____
Print Name:_____	NPI#: _____
Address:_____	
Phone:_____	Fax:_____