

Patient:		Date of Birth:	
Address:			
City:	State:	Zip:	
Phone:		Email:	
Diagnosis: <input type="checkbox"/> Obstructive Sleep Apnea (G47.33) <input type="checkbox"/> Central Sleep Apnea (G47.31) <input type="checkbox"/> Other _____ Prescribed Pressure: _____ Length of Need: _____ (1-99, 99=Lifetime) Prescribing Physician: _____ NPI: _____ Patient last Seen: _____ Patient's next scheduled appointment: _____			

PAP **CPAP (E0601)** **BIPAP with backup (E0471)** **BIPAP without backup (E0470)**

Range: <input type="checkbox"/> 4 to 20 cm <input type="checkbox"/> Pressure: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Change Pressure <input type="checkbox"/> Decrease _____ cm <input type="checkbox"/> Increase _____ cm <input type="checkbox"/> Other _____ Humidifier: <input type="checkbox"/> Heated Humidifier (K0562)

Supplies

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Full Face Mask (A7030)
<input type="checkbox"/> Face Mask Interface for full face replacement (A7031)
<input type="checkbox"/> Replacement Cushion for nasal app (A7032)
<input type="checkbox"/> Replacement Pillows for nasal app (A7033)
<input type="checkbox"/> Nasal Mask (A7034)
<input type="checkbox"/> Headgear (A7035) | <input type="checkbox"/> Chin Strap (A7036)
<input type="checkbox"/> Tubing (A7037)
<input type="checkbox"/> Heated Tubing (A4604)
<input type="checkbox"/> Oral Interface (A7044)
<input type="checkbox"/> Disposable Filters (A7038)
<input type="checkbox"/> Non-Disposable Filters (A7039) |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Completed/Requested by (please print): _____	
Phone: _____	Fax: _____
Physician signature: _____	Date: _____