CPAP WRITTEN ORDER FORM

Integrated HomeCare Services

YOUR REPRESENTATIVE: DEREK KILEY

INTEGRATED HOMECARE SERVICES

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PATIENT NAME: _____ D.O.B. _____ ORDER DATE: _____

PRIMARY PHONE NO. _____ PRIMARY INSURANCE: _____

ID # _____ GROUP # _____

PRESCRIBED MEDICAL EQUIPMENT:

Required: *if ordering a BiPAP or VPAP with out a backup rate (E0470), does the patient have a diagnosis of obstructive sleep apnea? If so, has CPAP been tried and proven ineffective?* ☐ *Yes* ☐ *No*

☐ Respironics ☐ ResMed

☐ E0601 CPAP _____ *CWP*

☐ E0601 Auto CPAP _____ *CWP* - _____ *CWP*

☐ E0470 BiLevel *IPAP* _____ *CWP* / *EPAP* _____ *CWP*

☐ E0470 Auto BiLevel *Min EPAP* _____ *CWP* / *Max IPAP* _____ *CWP*
PS _____ *(Res Med)*
min PS _____ *max PS* _____ *(Respironics)*

☐ CPAP SUPPLIES
Patient can use: A7027 Orl/Nsl Mask(1/3mo 3refills) A7028 Repl Oral/Nsl Mask(2/mo 1 1refills) A7029 Repl Nsl Pllw(2/mo 1 1refills) A7030 F/F Mask(1/3mo 3refills) A7031 FF Cshn(1/mo 1 1refills) A7032 Repl. Nsl Cshn(2/mo 1 1refills) A7033 Nsl Pllw(2/mo 1 1refills) A7034 Nsl Mask(1/3mo 3refills) A7035 Hdgr(1/6mo 1refill) A7036 Chn Strp (1/6mo 1refill) A7037/A4604 Tubing(1/3mo 3refills) A7038 Disp Fltrs(2/mo 1 1refills) A7039 Non Disp Fltrs(1/6mo 1refill) A7046 Wtr Chmbr(1/6mo 1refill)

☐ E0562 Heated Humidifier

☐ A4604 Heated Tubing

☐ E1390 Nocturnal Oxygen Concentrator
_____ *LPM to bleed in with NPAP*

☐ Other _____

DIAGNOSIS:

☐ ICD10 G47.33 Obstructive Sleep Apnea

☐ ICD10 G47.31 Central Sleep Apnea

☐ ICD10 G47.36 Complex Sleep Apnea

☐ ICD10 _____

WHAT IS THE AHI? _____

Required: *If the AHI is* ***(5 or greater and/or less than 15)*** *please check the additional symptoms:*

☐ Excessive Daytime Sleepiness ☐ Hypertension

☐ Impaired Cognition ☐ Insomnia

☐ Mood Disorders ☐ History of Stroke

☐ Ischemic Heart Disease

PATIENT PROGRESS DOWNLOAD:

☐ In one month

☐ Other _____

DURATION:

☐ LIFETIME 99 Months or ☐ _____

Special Equipment Instructions: _____

_____

The above patient has been diagnosed with obstructive sleep apnea by polysomography when required by insurance guidelines. The above prescribed treatment has been considered the best alternative therapy for this patient. If left untreated it is potentially life-threatening Patients will be re-evaluated yearly to review symptoms. This prescription and diagnosis certifies that the above ordered services are medically necessary for this patient.

PHYSICIAN SIGNATURE: _____ DATE: _____

Physician Name: _____

Address: _____

_____

Office Phone: _____ NPI# _____

Please Provide us with the following:

Order Contact Name: _____

✔ A clear copy of the patient's insurance care/info sheet

✔ A clean copy of the patient's most recent sleep study

✔ ALL RELEVANT EQUIPMENT, DIAGNOSIS, & START DATE FIELDS COMPLETED

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