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:_____

PRESCRIBED MEDICAL EQUIPMENT:

☐ 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)*

DIAGNOSIS:

☐ ICD10 G47.33 Obstructive Sleep Apnea

PATIENT PROGRESS DOWNLOAD:

☐ In one month

☐ Other_____

DURATION:

☐ LIFETIME 99 Months or ☐ _____

Special Equipment Instructions:_____

_____

☐ E0562 Heated Humidifier

☐ A7027 Combo Orl/Nsl Mask (1/3mo 3refills)

☐ A7028 Repl Combo Oral Cushion (2/mo 11refills)

☐ A7029 Repl Combo Nasal Pillow (2/mo 11refills)

☐ A7030 F/F Mask (1/3mo 3refills)

☐ A7031 Repl F/F Mask Interface (1/mo 11refills)

☐ A7034 Nasal Cushion/Pillow Mask (1/3mo 3refills)

☐ A7032 Repl Nasal Cushion (2/mo 11refills)

☐ A7033 Repl Nasal Pillow (2/mo 11refills)

☐ A7035 Headgear (1/6mo 1refill)

☐ A7036 Chin Strap (1/6mo 1refill),

☐ A7038 Disposable Filters (2/mo 11refills)

☐ A7039 Non Disposable Filters (1/6mo 1refill)

☐ A7046 Water Chamber (1/6mo 1refill)

☐ A7037 Tubing (1/3mo 3refills)

☐ A4604 Heated Tubing (1/3mo 3refills)

☐ E1390 Nocturnal Oxygen Concentrator
_____LPM to bleed in with PAP Device

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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