



PRESCRIPTION FOR DURABLE MEDICAL EQUIPMENT
All Offices Phone (877) 488-3800 (Menu #3 then #1 for Physician's Office)
Capitola / Monterey Fax (831) 886-3665
San Jose / East Bay / San Francisco Fax (408) 292-2727

Coding:

Patient Name:		Order Date: <i>(On or before signature date)</i>	
Patient Address:		Date of Birth:	
		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Specified	
Patient Phone:	Patient Cell:		
Primary Diagnosis:	<input type="checkbox"/> G47.33 Obstructive Sleep Apnea	<input type="checkbox"/> G47.31 Central Sleep Apnea	<input type="checkbox"/> J44.9 COPD <input type="checkbox"/> Other:
Secondary Diagnosis: <i>(Optional - If AHI < 15)</i>	<input type="checkbox"/> I10 (Hypertension)	<input type="checkbox"/> G47.10 Hypersomnia	<input type="checkbox"/> G47.00 Insomnia <input type="checkbox"/> Other:

NEW EQUIPMENT ORDERED

<input type="checkbox"/> CPAP (E0601) @: _____ CM H ₂ O	<input type="checkbox"/> Auto CPAP (E0601) @: _____ - _____ CM H ₂ O
<input type="checkbox"/> Bi-Level (E0470) @: _____ / _____ CM H ₂ O	
<input type="checkbox"/> Auto Bi-Level (E0470) @ IPAP Max: _____ EPAP Min: _____ Pressure Support: _____	
<input type="checkbox"/> ASV (E0471) @ EPAP Min: _____ EPAP Max: _____ PS Min: _____ PS Max: _____	
Comfort Setting (A-Flex / EPR): _____ Ramp time: _____ (min)	
<input type="checkbox"/> Bi-Level ST (E0471) @ IPAP: _____ EPAP: _____ Rate: _____	
<input type="checkbox"/> Heated Humidifier (E0562)	Estimated Length of Need (LON): _____ (99 = Lifetime)

SUPPLIES

Select all that apply. For Medicare beneficiaries, select only 1 mask type and 1 tubing type.

MASKS			TUBING
<u>Nasal Mask</u> <input type="checkbox"/> A7034 Nasal Mask (1 per 3 months) <input type="checkbox"/> A7032 Nasal Cushion (2 per month) <input type="checkbox"/> A7035 Headgear (1 per 6 months)	<u>Nasal Pillows Mask</u> <input type="checkbox"/> A7034 Nasal Pillows Mask (1 per 3 months) <input type="checkbox"/> A7033 Nasal Pillow (2 per month) <input type="checkbox"/> A7035 Headgear (1 per 6 months)	<u>Full Face Mask</u> <input type="checkbox"/> A7030 Full Face Mask (1 per 3 months) <input type="checkbox"/> A7031 Full Face Interface (Cushion) (1 per month) <input type="checkbox"/> A7035 Headgear (1 per 6 months)	<input type="checkbox"/> A4604 Heated Tubing (1 per 3 months) <input type="checkbox"/> A7037 Standard Tubing (1 per 3 months)
<input type="checkbox"/> Please Fit Mask / Patient Comfort <input type="checkbox"/> Or, Please Specify Mask:			
OTHER			
<input type="checkbox"/> A7038 Disposable Filter (2 per month)	<input type="checkbox"/> A7039 Non-Disposable Filter (1 per 6 months)	<input type="checkbox"/> A7036 Chinstrap (1 per 6 months)	<input type="checkbox"/> A7046 Water Chamber (1 per 6 months)

OTHER SERVICES

- | | |
|--|--|
| <input type="checkbox"/> Overnight Oximetry Study (ONO) | <input type="checkbox"/> Oxygen (E1390) Nocturnal @ _____ LPM |
| <input type="checkbox"/> Coordinate Sleep Study (PSG) | <input type="checkbox"/> Oxygen (E1390) Continuous (24 hours) @ _____ LPM |
| <input type="checkbox"/> Non-Invasive Ventilator (NIV) (E0466) | <input type="checkbox"/> Per nasal cannula <input type="checkbox"/> Bleed-in |

Physician Name:	NPI:
Address:	
Telephone Number:	Fax Number:
<i>I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.</i>	
Physician's Signature:	Signature Date:

(Stamped signatures not accepted)