CPAP Services
THE FINEST IN QUALITY SLEEP RELATED EQUIPMENT

PRESCRIPTION FOR DURABLE MEDICAL EQUIPMENT
Phone (877) 488-3800 (Menu #3 then #1 for Physician's Office)
Texas Fax (817) 962-2727

Patient Name:	**Order Date:** *(On or before signature date)*
Patient Address:	Date of Birth:
	Gender: ☐ Male ☐ Female ☐ Not Specified
Patient Phone:	Patient Cell:

Primary Diagnosis:	☐ **G47.33 Obstructive Sleep Apnea**	☐ G47.31 Central Sleep Apnea	☐ J44.9 COPD	☐ Other:
Secondary Diagnosis: *(Optional – If AHI < 15)*	☐ I10 (Hypertension)	☐ G47.10 Hypersomnia	☐ G47.00 Insomnia	☐ Other:

NEW EQUIPMENT ORDERED

☐ CPAP (E0601) (x1) @: _____ CM H_20 ☐ Auto CPAP (E0601) (x1) @: _____ - _____ CM H_20

☐ Bi-Level (E0470) (x1) @: _____ / _____ CM H_20

☐ Auto Bi-Level (E0470) (x1) @ IPAP Max: _____ EPAP Min: _____ Pressure Support: _____

☐ ASV (E0471) (x1) @ EPAP Min: _____ EPAP Max: _____ PS Min: _____ PS Max: _____

Comfort Setting (A-Flex / EPR): _____ Ramp time: _____ (min)

☐ Bi-Level ST (E0471) (x1) @ IPAP: _____ EPAP: _____ Rate: _____

☐ Heated Humidifier (E0562) (x1) 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
Nasal Mask ☐ A7034 Nasal Mask (1 per 3 months) ☐ A7032 Nasal Cushion (2 per month) ☐ A7035 Headgear (1 per 6 months)	Nasal Pillows Mask ☐ A7034 Nasal Pillows Mask (1 per 3 months) ☐ A7033 Nasal Pillow (2 per month) ☐ A7035 Headgear (1 per 6 months)	Full Face Mask ☐ A7030 Full Face Mask (1 per 3 months) ☐ A7031 Full Face Interface (Cushion) (1 per month) ☐ A7035 Headgear (1 per 6 months)	☐ A4604 Heated Tubing (1 per 3 months) ☐ A7037 Standard Tubing (1 per 3 months)

☐ Please Fit Mask / Patient Comfort ☐ Or, Please Specify Mask:

OTHER			
☐ A7038 Disposable Filter (2 per month)	☐ A7039 Non-Disposable Filter (1 per 6 months)	☐ A7036 Chinstrap (1 per 6 months)	☐ A7046 Water Chamber (1 per 6 months)

Physician Name:	NPI:
Address:	
Telephone Number:	Fax Number:

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.

Physician's Signature:	Signature Date:

(Stamped signatures not accepted)