

# CPAP WRITTEN ORDER FORM



INTEGRATED HOMECARE SERVICES  
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YOUR REPRESENTATIVE: DEREK KILEY

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 Oral/Nsl Mask(1/3mo 3refills) A7028 Repl Oral/Nsl Mask(2/mo 11refills)  
 A7029 Repl Nsl Pllw(2/mo 11refills) A7030 FIF Mask(1/3mo 3refills) A7031 FF Cshn(1/mo 11refills)  
 A7032 Repl. Nsl Cshn(2/mo 11refills) A7033 Nsl Pllw(2/mo 11refills) 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 Fitr(2/mo 11refills) A7039 Non Disp Fitr(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 polysomnography 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