


**R WRITTEN ORDER (RENEWAL/ANNUAL)  
CPAP/BIPAP SUPPLIES**

Date of Last Provider Visit \_\_\_\_\_

<b>Supplier Name, Address, Telephone &amp; NSC#:</b>   <b>713 Northway Dr.</b> <b>Anchorage, AK 99508</b> <b>Phone: (907) 274-0770      Fax: (907) 274-0773</b> <b>NSC#: 1267160001</b>	<b>Patient Name, Address, Telephone &amp; HIC#:</b>  (      )      -      HIC#:      .  <b>Patient DOB:      /      /      Sex:      (M/F)</b>
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The above named patient has an order for service, equipment and/or supplies that will and/or has expired on \_\_\_\_\_. In order to continue to dispense and/or supply services we require a renewal/extension written order. The information provided is based on the last order on record. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records. Prepared by: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Diagnosis and Code: \_\_\_\_\_

Length of Need (# of months): \_\_\_\_\_ 1-99 (99=life)

Patient Height: \_\_\_\_\_ ft. in.    Weight: \_\_\_\_\_ lbs.

**CPAP/BIPAP SUPPLIES:**

- Headgear (A7035) - 1 per every 6 months
- Tubing - Non-Heated (A7037) – 1 per every 3 months
- Tubing - Heated (A4604) – 1 per every 3 months
- Humidifier - Heated (E0562)
- Interface (Patient Preference)
  - Nasal Mask (A7034) - 1 per every 3 months
  - Nasal Prongs (A7033) – 2 per 1 month
  - Full Face Mask (A7030) – 1 per every 3 months
- Cushion Replacement
  - Cushion, Nasal Mask (A7032) - 2 per every 1 month
  - Cushion, Nasal Prongs (A7033) – 2 per 1 month
  - Cushion, Full Face Mask (A7031) – 1 per 1 month
- Filter, Pollen (A7038) - 2 per month
- Filter, Gross Particle (A7039) – 1 per 6 months
- Chin Strap (A7036) – 1 per 6 months
- Water Chamber, Humidifier (A7046) – 1 per 6 months

**OTHER SUPPLIES:**

- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**PROVIDER CERTIFICATION:**

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

\_\_\_\_\_  
Provider's Signature Date

\_\_\_\_\_  
Provider's Name

NPI: \_\_\_\_\_ Telephone: \_\_\_\_\_