℞ WRITTEN ORDER (RENEWAL/ANNUAL)
CPAP/BIPAP SUPPLIES

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **915 30th Avenue Suite 106** **Fair**banks**, AK 99701** **Phone: (907) 458-8912 Fax: (907) 458-8914** **NSC#: 1267160002**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

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:_____

Diagnosis and Code: _____

Length of Need (# of months): _____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

CPAP/BIPAP SUPPLIES:

Mask Interface (Select only one mask)

- ☐ Nasal Mask (A7034) - 1 every 3 months
- ☐ Full Face Mask (A7030) - 1 every 3 months
- ☐ Nasal Cushion (A7032) - 2/mo
- ☐ Nasal Pillow (A7033) - 2/mo
- ☐ Full Face Cushion (A7031) - 1/mo
- ☐ Headgear (A7035) - 1 every 6 months
- ☐ Heated Tubing (A4604) - 1 every 3 months
- ☐ Filter, Pollen (A7038) - 2/mo
- ☐ Filter, Gross Particle (A7039) - 1 every 6 months
- ☐ Chin Strap (A7036) - 1 every 6 months
- ☐ Water Chamber, Humidifier (A7046) - 1 every 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: _____

Updated 07-23-20