℞ 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 **901 N Leatherleaf Loop Suite 104** **Wasilla, AK 99654** **Phone: (907) 357-7882** **Fax: (907) 357-7883** **NSC#: 1267160003**	**( ) - 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 06/21/2018. 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: _____