


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

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

<b>Supplier Name, Address, Telephone &amp; NSC#:</b>  <b>901 N Leatherleaf Loop Wasilla, AK 99654 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1267160003</b>	<b>Patient Name, Address, Telephone &amp; Insurance ID#:</b>  ( ) - Ins ID #:  <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: \_\_\_\_\_

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

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

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

**CPAP/BIPAP SUPPLIES:**

- 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

**Mask Interface (Select only one mask)**

- Nasal Mask (A7034) - 1 every 3 months
- Nasal Cushion (A7032) - 2/mo
- Nasal Pillow (A7033) - 2/mo
  
- Full Face Mask (A7030) - 1 every 3 months
- Full Face Cushion (A7031) - 1/mo

**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: \_\_\_\_\_