

**R WRITTEN ORDER AND MEDICAL JUSTIFICATION
CPAP & BiPAP**

Supplier Name, Address, Telephone & NSC#: Procare Home Medical 901 N Leatherleaf Loop Wasilla, AK 99654 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1267160003	Patient Name, Address, Telephone & Insurance ID #: (____) _____ - _____ Ins ID#: _____ Patient DOB: ____ / ____ / ____ Sex: ____ (M/F)
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We have been asked to provide the following equipment to the patient named above. 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.

Clinical Information		
Diagnosis (Choose One)	<input type="checkbox"/> Obstructive Sleep Apnea (G47.33)	Sleep Study Summary Information
	<input type="checkbox"/> Central Sleep Apnea (G47.31)	AHI = _____ (Note: 5-14 AHI's must have a co-morbidity)
	<input type="checkbox"/> Sleep Hypoventilation (G47.34)	Co-Morbidity = _____
	<input type="checkbox"/> Other: _____	# Apneas = _____ # Hypopneas = _____
LON	<input type="checkbox"/> 14 days w Titration Assessment	Lowest O2 Sat. = _____
	<input type="checkbox"/> 30 days w Titration Assessment	Note: A sleep studies oximetry cannot be used to qualify stand alone nocturnal oxygen. A separate nocturnal oximetry test is required.
	<input type="checkbox"/> 99 Life Time Need w Initial Titration Assessment	
	<input type="checkbox"/> 99 Life Time Need	

Orders	
<input type="checkbox"/> BiPAP	<input type="checkbox"/> CPAP
IPAP Pressure = _____	Pressure = _____
EPAP Pressure = _____	C-Flex Setting = _____
Bi-Flex Setting = _____	<input type="checkbox"/> CPAP – Auto
<input type="checkbox"/> BiPAP Auto	Minimum Pressure = _____
IPAP Maximum Pressure = _____	Maximum Pressure = _____
Maximum Pressure Support = _____	Supplemental Oxygen
Minimum Pressure Support = _____	<input type="checkbox"/> Continuous Oxygen at _____ LPM
EPAP Minimum Pressure = _____	<input type="checkbox"/> Nocturnal Oxygen at _____ LPM
Rise Time = _____	<input type="checkbox"/> Bleed into CPAP/BiPAP when sleeping
<input type="checkbox"/> BiPAP S/T	Supplies (Select all that apply)
IPAP Pressure = _____	<input type="checkbox"/> Headgear (A7035) - 1 per every 6 months
EPAP Pressure = _____	<input type="checkbox"/> Tubing - Heated (A4604) – 1 per every 3 months
Rate = _____	<input type="checkbox"/> Humidifier - Heated (E0562)
I Time = _____	<input type="checkbox"/> Filter, Pollen (A7038) - 2 per month
Rise Time = _____	<input type="checkbox"/> Filter, Gross Particle (A7039) – 1 per 6 months
<input type="checkbox"/> BiPAP - Auto SV (Ventilation)	<input type="checkbox"/> Chin Strap (A7036) – 1 per 6 months
Pressure Support Minimum Pressure = _____	<input type="checkbox"/> Humidifier - Non-Heated (E0561)
Pressure Support Maximum Pressure = _____	<input type="checkbox"/> Water Chamber, Humidifier (A7046) – 1 per 6 months
EPAP Minimum Pressure = _____	Mask Interface (Select only one mask)
EPAP Maximum Pressure = _____	Nasal Mask (A7034) - 1 per every 3 months
Max Pressure = _____	Nasal Cushion (A7032) - 2 per 1 month
Rate = _____	Nasal Pillow (A7033)- 2 per 1 month
I Time = _____	Full Face Mask (A7030) – 1 per every 3 months
Rise Time = _____	Full Face Cushion (A7031) - 1 month

Comments:	Provider Certification: I, the patients treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.
	Provider Signature _____ Date _____

Provider Name

NPI #