

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

Start Date: _____

Supplier Name, Address, Telephone & NSC#: Procure Home Medical 713 Northway Dr. Anchorage, AK 99508 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001	Patient Name, Address, Telephone & HIC#: (____) _____ - _____ HIC#: _____ 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) <input type="checkbox"/> Central Sleep Apnea (G47.31) <input type="checkbox"/> Sleep Hypoventilation (G47.34) <input type="checkbox"/> Other: _____	Sleep Study Summary Information AHI = _____ (Note: 5-14 AHI's must have a co-morbidity) Co-Morbidity = _____ # Apneas = _____ # Hypopneas = _____ Lowest O2 Sat. = _____
LON	<input type="checkbox"/> 14 days w Titration Assessment <input type="checkbox"/> 30 days w Titration Assessment <input type="checkbox"/> 99 Life Time Need w Initial Titration Assessment <input type="checkbox"/> 99 Life Time Need	Note: A sleep studies oximetry cannot be used to qualify stand alone nocturnal oxygen. A separate nocturnal oximetry test is required.

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 - Non-Heated (A7037) – 1 per every 3 months
Rate = _____	<input type="checkbox"/> Tubing - Heated (A4604) – 1 per every 3 months
I Time = _____	<input type="checkbox"/> Humidifier - Heated (E0562)
Rise Time = _____	<input type="checkbox"/> Interface (Patient Preference)
<input type="checkbox"/> BiPAP - Auto SV (Ventilation)	Nasal Mask (A7034) - 1 per every 3 months
Pressure Support Minimum Pressure = _____	Nasal Prongs (A7033, A7032) – 2 per 1 month
Pressure Support Maximum Pressure = _____	Full Face Mask (A7030) – 1 per every 3 months
EPAP Minimum Pressure = _____	Full Face Cushion (A7031) – 2 per 1 month
EPAP Maximum Pressure = _____	<input type="checkbox"/> Filter, Pollen (A7038) - 2 per month
Max Pressure = _____	<input type="checkbox"/> Filter, Gross Particle (A7039) – 1 per 6 months
Rate = _____	<input type="checkbox"/> Chin Strap (A7036) – 1 per 6 months
I Time = _____	<input type="checkbox"/> Humidifier - Non-Heated (E0561)
Rise Time = _____	<input type="checkbox"/> Water Chamber, Humidifier (A7046) – 1 per 6 months

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 #