℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
CPAP & BiPAP

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID #:**
Procare Home Medical **4215 Credit Union Dr.** **Anchorage, AK 99508** **Phone: (907) 274-0770 Fax: (907) 274-0773** **NSC#: 1267160001**	**(_____) _____ - _____ Ins ID#: _____** **Patient DOB:_____/_____/_____ Sex:_____ (M/F)**

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)	☐ Obstructive Sleep Apnea (G47.33)	**Sleep Study Summary Information**
	☐ Central Sleep Apnea (G47.31)	AHI = (Note: 5-14 AHI's must have a co-morbidity)
	☐ Sleep Hypoventilation (G47.34)	Co-Morbidity =
	☐ Other:	# Apneas = # Hypopneas =
LON	☐ 14 days w Titration Assessment	Lowest O2 Sat. =
	☐ 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.
	☐ 99 Life Time Need w Initial Titration Assessment	
	☐ 99 Life Time Need	

Orders	
☐ **BiPAP**	☐ **CPAP**
IPAP Pressure =	Pressure =
EPAP Pressure =	C-Flex Setting =
Bi-Flex Setting =	☐ **CPAP – Auto**
☐ **BiPAP Auto**	Minimum Pressure =
IPAP Maximum Pressure =	Maximum Pressure =
Maximum Pressure Support =	**Supplemental Oxygen**
Minimum Pressure Support =	☐ Continuous Oxygen at LPM
EPAP Minimum Pressure =	☐ Nocturnal Oxygen at LPM
Rise Time =	☐ Bleed into CPAP/BiPAP when sleeping
☐ **BiPAP S/T**	**Supplies (Select all that apply)**
IPAP Pressure =	☐ Headgear (A7035) - 1 per every 6 months
EPAP Pressure =	☐ Tubing - Heated (A4604) – 1 per every 3 months
Rate =	☐ Humidifier - Heated (E0562)
I Time =	☐ Filter, Pollen (A7038) - 2 per month
Rise Time =	☐ Filter, Gross Particle (A7039) – 1 per 6 months
☐ **BiPAP - Auto SV (Ventilation)**	☐ Chin Strap (A7036) – 1 per 6 months
Pressure Support Minimum Pressure =	☐ Humidifier - Non-Heated (E0561)
Pressure Support Maximum Pressure =	☐ 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 #