

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

Start Date: \_\_\_\_\_

<b>Supplier Name, Address, Telephone &amp; NSC#:</b> Procure Home Medical 901 N Leatherleaf Loop Suite 104 Wasilla, AK 99654 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1267160003	<b>Patient Name, Address, Telephone &amp; HIC#:</b> (____) _____ - _____ 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		
<b>Diagnosis (Choose One)</b>	<input type="checkbox"/> Obstructive Sleep Apnea (G47.33)	<b>Sleep Study Summary Information</b>
	<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 = _____
<b>LON</b>	<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"/> <b>BiPAP</b>	<input type="checkbox"/> <b>CPAP</b>
IPAP Pressure = _____	Pressure = _____
EPAP Pressure = _____	C-Flex Setting = _____
Bi-Flex Setting = _____	<input type="checkbox"/> <b>CPAP – Auto</b>
<input type="checkbox"/> <b>BiPAP Auto</b>	Minimum Pressure = _____
IPAP Maximum Pressure = _____	Maximum Pressure = _____
Maximum Pressure Support = _____	<b>Supplemental Oxygen</b>
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"/> <b>BiPAP S/T</b>	<b>Supplies (Select all that apply)</b>
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"/> <b>BiPAP - Auto SV (Ventilation)</b>	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

<b>Comments:</b>	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 #