CPAP & BIPAP STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to :
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID #:

(_____) _____ - _____ Ins ID#: _____

Patient DOB:_____/_____/_____ Sex:_____ (M/F)

Refer to CPAP/BIPAP coverage criteria sheet for all required documentation:

CPAP & BIPAP:

Diagnosis (Choose One) ☐ Obstructive Sleep Apnea (G47.33) ☐ Central Sleep Apnea (G47.31) ☐ Sleep Hypoventilation (G47.34)
☐ Other: _____

Length of Need (# of months) _____ 1-99 (99=life) Date of last visit: _____

☐ **CPAP (E0601) with heated humidifier (E0562):**
Pressure = ___ (4-20 cmH2O), Expiratory Relief ___ (1-3)
Ramp time ___ minutes (Auto or 0-45 minutes)

☐ **CPAP-AUTO (E0601) with heated humidifier (E0562):**
Min pressure = ___ (4-20 cmH20) Max pressure = ___ (4-20 cmH20),
Expiratory Relief ___ (1-3), Ramp time ___ minutes (Auto or 0-45 minutes)

☐ **BiLevel S (E0470) with heated humidifier (E0562):**
IPAP = ___ (4-25 cmH20), EPAP = ___ (3-25 cmH20),
Easy Breath ___ (On or Off)

☐ **BiLevel-AUTO(E0470) with heated humidifier (E0562):**
☐ Auto Mode
Max IPAP = ___ (4-25 cmH20), Min EPAP = ___ (4-25 cmH20), Pressure Support = ___ (0-10 cmH20), Ramp time ___ minutes (Auto or 0-45 minutes)
☐ Spontaneous Mode
Max IPAP = ___ (4-25 cmH20), Min EPAP = ___ (4-25 cmH20), Ramp time ___ minutes (Auto or 0-45 minutes)

☐ **BiLevel S/T (E0471) with heated humidifier (E0562):**
IPAP = ___ (4-25 cmH2O), EPAP = ___ (4-25 cmH2O), RR = ___, Rise Time = ___ (100-900 ms, Rise of 1 = 100 ms, 2 = 200 ms, 3 = 300 ms etc.)

☐ **BiLevel (ASV) (E0471) with heated humidifier (E0562):**
☐ ASV Mode ☐ ASV Auto Mode
Min EPAP =___ (4-15 cmH2O), Max EPAP = ___(4-15 cmH20), Min Pressure Support (PS) = ___ (0-6 cmH20), Max Pressure Support (PS) = ___ (5-20 cmH2O), Has Automatic Dynamic back up rate built-in, automatic easy breath waveform.

☐ **BiLevel Aircurve S/T-A (E0471) with heated humidifier (E0562):**
☐ Timed Mode
IPAP = ___ (4-24 cmH2O), EPAP = ___ (4-25 cmH2O), RR = ___,
Ti (inspiratory time =___ (0.1-4.0 sec), Rise Time = ___ (100-900 ms, Rise of 1 = 100 ms, 2 = 200 ms, 3 = 300 ms etc.)
☐ S/T Mode
IPAP = ___ (4-24 cmH2O), EPAP = ___ (4-25 cmH2O), RR = ___,
Ti (inspiratory time =___ (0.1-4.0 sec), Rise Time = ___ (100-900 ms, Rise of 1 = 100 ms, 2 = 200 ms, 3 = 300 ms etc.)
☐ iVAPS Mode
Height = ___ In. (44-100 inches)
Target RR = ___, Target tidal volume = ____, EPAP = ___, Pressure Support Min = ___ (0-20 cmH2O), Pressure Support Max = ___ (0-27 cmH2O)

Supplemental Oxygen

☐ Continuous Oxygen at _____ ☐ Nocturnal Oxygen at _____ ☐ Bleed into CPAP/BiPAP when sleeping

Supplies

☑ Full face mask (A7030) w/ headgear (A7035) every 3 months, with 1 FF cushion (A7031) every month

☑ Nasal mask (A7034) w/ headgear (A7035) every 3 months, with 2 nasal cushions (A7032) or 2 nasal pillows (A7033) every month

☑ Tubing - Heated (A4604) or Non-Heated (A7037) 1 every 3 months

☑ Water Chamber (A7046) - 1 every 6 months

☑ Chin Strap (A7036) - 1 every 6 months

☑ Filter, Disposable (A7038) - 2/month

☑ Filter, Non-disposable (A7039) - 1 every 6 months

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: _____ NPI: _____

Provider Name: _____ Telephone: _____