RENEWAL CPAP/BIPAP SUPPLIES 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)

In order to continue to dispense and/or supply services we require a renwal/extension order. This information is based on the last order on record. Please review and verify this information

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: _____

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: _____