California Sleep, Inc.

Prescription for Durable Medical Equipment

Patient Name:	Gender:
Street Address:	DOB:
City, State, Zip:	Primary Insurance:
Email Address:	Insurance ID:
Primary Phone:	Secondary Insurance:
Secondary Phone:	Insurance ID:

Medical Necessity (Diagnosis) *Check all that apply
☐ G47.33 - Obstructive Sleep Apnea
☐ G47.31 - Central Sleep Apnea
☐ Other:

PAP Equipment *Check and fill in the PAP settings			
Machine	**CPT Code**	**Pressure Settings**	
☐ CPAP	E0601		cm/H2O
☐ CPAP Auto	E0601	Minimum:	cm/H2O
		Maximum:	cm/H2O
☐ BiPAP	E0470	IPAP:	cm/H2O
		EPAP:	cm/H2O
☐ BiPAP Auto	E0470	Max IPAP:	cm/H2O
		Min EPAP:	cm/H2O
		Min PS:	cm/H2O
		Max PS:	cm/H2O
☐ BiPAP ST	E0471	IPAP:	cm/H2O
		EPAP:	cm/H2O
		Backup Rate:	
		Timed Inspiration:	
		Rise Time	
☐ BiPAP ST AVAPS	E0471	IPAPmin:	cm/H2O
		IPAPmax:	cm/H2O
		EPAP:	cm/H2O
		Tidal	mL
		Backup Rate:	BPM
		Timed Inspiration:	
		Rise Time:	

Pap Supplies	**Frequency Limit**	**Quantity**
A4604 – Heated Tubing	One Per Six Months	4
A7030 – Full Face Mask	One Per Year	4
A7031 – Full Face Cushion	One Per Year	2
A7032 – Nasal Cushion	One Per Month	2
A7033 – Nasal Pillow	Two Per Month	2
A7034 – Nasal Mask	One Per Six Months	4
A7035 – Headgear	One Per Six Months	2
A7036 – Chin Strap	One Per Six Months	2
A7037 – Tubing	One Per Six Months	4
A7038 – Disposable Filter	Two Per Month	2
A7039 – Reusable Filter	One Per Six Months	2
A7046 – Water Chamber	One Per Six Months	2
E0562 – Heated Humidifier	One Time Only	1

PAP Equipment cont. *Check and fill in the PAP settings			
Machine	**CPT Code**	**Pressure Settings**	
☐ BiPAP ST AutoSV	E0471	Min EPAP:	cm/H2O
		Max EPAP:	cm/H2O
		Min PS:	cm/H2O
		Max PS:	cm/H2O
		Max Pressure:	cm/H2O
		Backup Rate:	BPM
Other:			

Statement of Medical Necessity

The patient indicated has an absolute medical necessity for the items listed above. I certify that the items prescribed are reasonable and medically necessary with reference to the standards of medical practice for this patient's diagnosis. The length of need for the equipment and supplies will be **lifetime.** *(Unless otherwise indicated)

***Length of need will end on the following date:** (Only list a date if not lifetime)

Physician Signature **Physician Name (Printed)** **Date Signed** **NPI Number**