NW REST

Transfer of Care Form

365 Warner Milne Rd. Suite 209 | Oregon City, OR 97045
Phone: (503) 495-6200 | Fax: (503) 495-6208

Patient Information	
Name:	Birthdate:
Phone:	Email:
Address:	
ICD-10: G47.33 (Obstructive Sleep Apnea)	Length of Need (LON): 99
Previous DME:	
Equipment	
☐ Full Face Mask (A7030) - 1 per 3 months	☐ Climate Tubing (A4604) - 1 per 3 months
☐ Full Face Cushion (A7031) - 1 per month	☐ Tubing (A7037) - 1 per 6 months
☐ Nasal Mask (A7034) - 1 per 3 months	☐ Disposable Filters (A7038) - 2 per month
☐ Nasal Cushions (A7032) - 2 per month	☐ Reusable Filter (A7039) - 1 per 6 months
☐ Nasal Pillows (A7033) - 2 per month	☐ Water Chamber (A7046) - 1 per 6 months
☐ Headgear (A7035) - 1 per 6 months	☐ Chinstrap (A7036) - 1 per 6 months
Ordering Provider	
Name:	NPI:
Phone:	Fax:
Address:	
Signature:	Date:

Letter of Medical Necessity: I, the undersigned, certify that the above prescribed service is medically necessary as part of my medical treatment for this patient. It is my opinion that the equipment ordered on this form is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition.