NW REST

PAP Therapy Order 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
Equipment	
☐ Auto CPAP (E0601): _____cmH20	☐ Nasal Pillows (A7033) - 2 per month
☐ Humidifier (E0562)	☐ Headgear (A7035) - 1 per 6 months
☐ Modem (A9279)	☐ Climate Tubing (A4604) - 1 per 3 months
☐ Full Face Mask (A7030) - 1 per 3 months	☐ Disposable Filters (A7038) - 2 per month
☐ Full Face Cushion (A7031) - 1 per month	☐ Reusable Filter (A7039) - 1 per 6 months
☐ Nasal Mask (A7034) - 1 per 3 months	☐ Water Chamber (A7046) - 1 per 6 months
☐ Nasal Cushions (A7032) - 2 per month	☐ 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.