Patient Name: _____ Patient DOB: _____

Patient Address: _____ Diagnosis: _____

Insurance: _____ Policy Number: _____

Ordering Physician: _____ Ordering Physician NPI: _____

Order Date: _____ Length of Need for Items Listed Below: 99 months (99=lifetime)

Base Equipment:

- ☐ E0601 CPAP Machine — Pressure Setting: _____
- ☐ E0470 BIPAP Machine
- ☐ E0471 BIPAP ST Machine with Backup Rate
- ☐ E0562 Heated Humidifier

Related Supplies to be provided at setup and replaced as necessary at the intervals noted.

☐	A7030 Full Face Mask for PAP	Replace 1 every 3 months
☐	A7034 Nasal Mask for PAP	Replace 1 every 3 months
☐	A7027 Combination Mask Oral/Nasal for PAP	Replace 1 every 3 months
☐	A7044 Oral Interface for PAP	Replace 1 every 3 months
☐	A7035 Headgear for PAP Mask	Replace 1 every 6 months
☐	A7036 Chinstrap for PAP Therapy	Replace 1 every 6 months
☐	A7037 Tubing for PAP	Replace 1 every 3 months
☐	A4604 Tubing, Heated for PAP	Replace 1 every 3 months
☐	A7038 Filter, Disposable for PAP	Replace 2 every month
☐	A7039 Filter, Non-Disposable	Replace 1 every 6 months
☐	A7046 Water Chamber for PAP	Replace 1 every 6 months
☐	A7031 Cushion for Full Face Mask	Replace 1 every month
☐	A7032 Cushion for Nasal Mask	Replace 2 every month
☐	A7033 Cushion for Nasal Pillow	Replace 2 every month

- ☑ Assess and interchange mask interface as needed for optimal patient comfort and compliance.

Therapeutic Objectives: Treatment of sleep apnea, decrease AHI, improve daytime sleepiness. Pap machine and supplies to be used nightly 4 hours or more to obtain compliance and maximum benefit.

_____ _____

Physician Signature **Date**

I authorize the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable, and is not being prescribed for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.