CPAP & BIPAP STANDARD WRITTEN ORDER

AZ Diabetic
386 Maple Ave E Ste 113
Vienna, VA, 22180-4755
Diabetic & Medical Supply Specialist
Call: 877-833-0001
Fax: 703-356-5516

Patient Name, Address, Telephone & Insura nce ID #:

_____ _____ _____ **Ins ID#:**_____

_____ **Sex:**_____ **(M/F)**

CPAP & BIPAP: ☐ Obstructive Sleep Apnea (G47.33) ☐Central SleepApnea(G47.31)☐SleepHyp oventilation (G47.34)
(Choose One)
☐ Others
Diagnosis _____
Length of Need (# of months) _____ 1-99 (99=life) Date of last visit: _ _____

▫ **CPAP (E0601)** Pressure=____ C-Flex Setting = ____
with heated humidifier (E0562)

▫ **CPAP–Auto (E0601)**Min Pressure =____ Max Pressure = ____
with heated humidifier (E0562)

BiPAP (E0470)IPAP Pressure=____ EPAP Pressure = ____
with heated humidifier (E0562) Bi-Flex Setting = ____

☐**BiPAP Auto(E0470)**IPAP Maximum Pressure=____
with heated humidifier (E0562) Min. Pressure Support = _____
M ax Pressure Support = ____ EPAP Min Pressure =____ Rise Time = ___

BiPAP S/T(E0471)IPAP Pressure =____ EPAP Pressure = ____
with heated humidifier (E0562) Rate = ____ I Time = _ _ _ _ R i s e T i m

BiPAP-Auto SV (Ventilation)(E0471)
with heated humidifier (E0562) Min Pressure Support =____
Max Pressure Support = __ _ _ EPAP Min Pressure =____
EPAP Max Pressure = ____ Rate = ____ I Time = ____ Rise Time =____

Supplies

One mask interface must be selected for Medicare recipients (cannot indicate patient preference)

Nasal Mask Supplies Include: OR

Nasal Mask (A7034) - 1 every 3 months
Headgear (A7035) - 1 every 6 months
Nasal Cushion (A7032) or Nasal Pillow (A7033) - 2/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
Other:_____

Full Face Mask Supplies Include:

Full Face Mask(A7030)–1 perevery3months
Headgear (A7035) - 1 every 6 months
Full Face Cushion(A7031) -1 month
Tubing - Heated (A4604) or Non-Heated (A7037) 1 every 3
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
Other:_____

Supplemental Oxygen

Continuous Oxygen at_____

Nocturnal Oxygen at_____

Bleed into CPAP/BiPAP when sleeping

Provider Certification:
I, thepatients treatingprovider, certify the medical necessity of these items for this patient and maintain medical records reflecting th medical justification and care provided.

Provider Signature: _____ ____ Date: _____ NPI: _____ _ _ _ _ _____

Provider Name: _____ Telephone: _____