MSC Sleep
Division of Medical Service Company

Please Fax Completed Form to 1-866-837-5337

Please provide copies of both patient's DEMOGRAPHIC and INSURANCE information.

Patient Name: _____ ***Date Prescribed:*** _____/_____/_____

Address: _____ Insurance: _____

City/Zip: _____ Gender: _____ Length of need: 99

Home Phone/Cell#: _____ Diagnosis: _____

D.O.B: _____/_____/_____ *PAP Diagnosis*: ☐ OSA

All services require a method of payment (credit card, bank information) in addition to insurance information prior to delivery.

Oxygen Diagnosis: ☐ Chronic Bronchitis ☐ Cystic Fibrosis ☐ CHF ☐ COPD ☐ Emphysema

CPAP/BILEVEL with heated humidity (tubing, filters & all related supplies)

Please include copy of SLEEP STUDY.

☐ CPAP _____ cm H_2O ☐ APAP _____ to _____ cm H_2O ☐ Heated Humidifier

☐ BiLevel IPAP = _____ EPAP =_____ ☐ Bleed in O_2 @ _____ LPM ☐ Concentrator

☐ BiLevel Auto EPAP min = _____ IPAP max = _____ PS _____

PULSE OXIMETRY SERVICES
(where available)

☐ Overnight Oximetry

On:

☐ PAP Device

MASK & SUPPLIES

☐ NASAL MASK KIT
- Nasal Mask (1 per 3 mos.) _____
- Heated PAP Tubing (1 per 3 mos.)
- Nasal Cushions (2 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

☐ PILLOW MASK KIT
- Pillow Mask (1 per 3 mos.) _____
- Heated PAP Tubing (1 per 3 mos.)
- Nasal Pillows (2 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

☐ FULL FACE MASK KIT
- Full Face Mask (1 per 3 mos.) _____
- Heated PAP Tubing (1 per 3 mos.)
- Full Face Cushions (1 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing equipment. Suppliers are required to obtain chart notes from the visit AND obtain a written order PRIOR to delivery that consists of the item AND

1) Patient Name 2) Date Prescribed 3)Physician Signature & Signature Date 4) NPI 5) Physician Name

Physician's Signature: _____ ***Date:*** _____/_____/_____

Physician's Printed Name: _____ Ph: _____ Fax : _____

Physician's Address: _____ ***NPI:*** _____

Name of Agent Completing Form: _____

www.MSCSleep.com