Medical Service Company

CPAP/APAP/BiLevel Order Form

Sales Rep Name: _____
Phone #: _____
Fax #: _____

PATIENT INFORMATION

Patient Name: _____ Date Prescribed: ____/____/____
Date of Birth: ____/____/____ Length of Need: 99 months (lifetime) OR _____ # of months)
Home Phone/Cell #: _____ ICD-10 (Diagnosis): ☐ OSA ☐ Other _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____

CPAP/APAP/BILEVEL EQUIPMENT (OSA)

☐ **CPAP** (E0601) w/heated humidifier (E0562) _____ cm H_20
☐ **APAP** (E0601) w/heated humidifier (E0562) _____ to _____ cm H_20
☐ **BiLevel** (E0470) w/heated humidifier (E0562) **EPAP**_____ **IPAP**_____
☐ **BiLevel Auto** (E0470) w/heated humidifier (E0562) **EPAP min**_____ **IPAP max**_____ **PS**_____

OXYGEN/PULSE OXIMETRY

☐ Bleed in O_2 Concentrator @ _____ LPM

PULSE OXIMETRY SERVICES

☐ Overnight Oximetry on PAP Device

MASK

☐ Nasal Mask, Nasal Pillow Mask or Full-Face Mask Kit (1 per 3 months)
☐ Other (Name of Mask): _____ but if the patient cannot tolerate it, provide mask of choice

SUPPLIES *(check all applicable boxes)*

☐ Nasal Cushions (2 per month)
☐ Nasal Pillows (2 per month)
☐ Full Face Cushions (1 per month)
☐ Headgear (1 per 6 months)
☐ Chinstrap (1 per 6 months)
☐ Disposable Filters (2 per month)
☐ Heated Tubing (1 per 3 months)
☐ Standard Tubing (1 per 3 months)
☐ Water Chamber (1 per 6 months)

INCLUDE THIS DOCUMENTATION TO DISPENSE AND BILL:

☐ **Clinical evaluation prior to the sleep test to assess possible OSA signed and dated by the Physician.**
☐ **Sleep Study signed and dated by the Interpreting Physician (most payors require testing to be scored at 4%).**
☐ **If oxygen bleed-in is needed, a copy of the Titration Study signed and dated by the Interpreting Physician.**

Physician's Signature: _____ **Date:** ____/____/____
Physician's Printed Name: _____ **NPI:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ **Fax:** _____