Medical Service Company

PAP Supply Order Form

Sales Rep Name: ______________________

Phone #: ______________________

Fax #: ______________________

PATIENT INFORMATION

Patient Name: ______________________

Date of Birth: ______ / ______ / ______

Home Phone/Cell #: ______________________

Address: ______________________

City: __________ **State:** ______ **Zip:** ______

Email: ______________________

Date Prescribed: ______ / ______ / ______

Length of Need: 99 months (lifetime) OR ______ **# of months)**

ICD-10 (Diagnosis): ☐ **OSA** ☐ **Other** __________

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%).**

Physician's Signature: ______________________ **Date:** ______ / ______ / ______

Physician's Printed Name: ______________________ **NPI:** __________

Address: ______________________ **City:** __________ **State:** ______ **Zip:** ______

Phone: ______________________ **Fax:** __________