



Respiratory Assistance Device (RAD) 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): _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____

BILEVEL/ASV EQUIPMENT

- ☐ BiLevel (E0470) w/heated humidifier (E0562) EPAP _____ IPAP _____
☐ BiLevel Auto (E0470) w/heated humidifier (E0562) EPAP min _____ IPAP max _____ PS _____
☐ BiLevel ST (E0471) w/heated humidifier (E0562) PAP _____ EPAP _____ Rate _____
☐ BiLevel ST-A (E0471) Va Target _____ EPAP _____ PS min _____ PS max _____ Rate _____
☐ ASV (E0471) w/heated humidifier (E0562) EPAP _____ PS min _____ PS max _____
Rate: Automatic (15 BPM)
☐ ASV Auto (E0471) w/heated humidifier (E0562) EPAP min _____ EPAP max _____
PS min _____ PS max _____ Rate _____ (Auto, 4-30, OFF)

OXYGEN/PULSE OXIMETRY

- ☐ Bleed in O₂ 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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Nasal Cushions (2 per month) | <input type="checkbox"/> Headgear (1 per 6 months) | <input type="checkbox"/> Heated Tubing (1 per 3 months) |
| <input type="checkbox"/> Nasal Pillows (2 per month) | <input type="checkbox"/> Chinstrap (1 per 6 months) | <input type="checkbox"/> Standard Tubing (1 per 3 months) |
| <input type="checkbox"/> Full Face Cushions (1 per month) | <input type="checkbox"/> Disposable Filters (2 per month) | <input type="checkbox"/> 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: _____

