Select Branch or Representative

RAD Fax Order Form

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

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

Address: _____ Insurance: _____

City/Zip: _____ Diagnosis: _____

Home Phone/Cell#: _____ Gender: _____ Length of need: _____99_____

Height: _____ Weight: _____ D.O.B: _____

☐ Restrictive Thoracic Disorder* _____

☐ COPD _____

☐ Central/Complex Sleep Apnea* _____

☐ Hypoventilation* _____

**physician to indicate diagnosis code*

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

EMPLOYEE USE ONLY □ ***CC secured***

BILEVEL w/ Backup Rate Therapy ***PLEASE INCLUDE COPY OF SLEEP STUDY***

☐ **BiLevel** (E0470) w/heated humidification (E0562) IPAP _____ EPAP _____

☐ **BiLevel Auto** (E0470) w/ heated humidification (E0562) EPAP min _____ IPAP max _____ PS _____

☐ **BiLevel ST** (E0471) w/ heated humidification (E0562) PAP _____ EPAP _____ Rate _____

☐ **ASV** (E0471) w/ heated humidification

- ☐ ASV EPAP _____ PS min _____ PS max _____ Rate: Automatic (15 BPM)
- ☐ ASV Auto EPAP min _____ EPAP max _____ PS min _____ PS max _____ Rate _____ (Auto, 4-30, OFF)
  Max Pressure _____ (if not Auto Rate)

☐ Bleed in O_2 @ _____ LPM

MASK & SUPPLIES

☐ **NASAL MASK, NASAL PILLOW MASK OR FULL FACE MASK KIT (1 PER 3 MONTHS)**

- Standard Tubing or Heated Tubing (1 per 3 months)
- Nasal Cushions (2 per month)
- Nasal Pillows (2 per month)
- Full Face Cushions (1 per month)
- Water Chamber (1 per 6 months)
- Headgear used with PAP mask (1 per 6 months)
- Chinstrap (1 per 6 months)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 months)

I would like my patient to start with _____ but if they cannot tolerate it, please provide mask of choice.
Name of Mask

ADDITIONAL ITEMS ORDERED: _____

_____

ADDITIONAL NOTES: _____

_____

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

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

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

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

Name of Agent Completing Form: _____

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