MSC Sleep
Division of Medical Service Company

**Select Branch or Representative**

***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, 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

**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**