Medical Service Company | MSC Sleep — Division of Medical Service Company

Please fax completed form to 1-877-824-1411

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 KIT
- Pillow Mask (1 per 3 mos.) _____
- Heated PAP Tubing (1 per 3 mos.)
- Nasal Pillows (2 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

☐ PILLOW MASK KIT
- Pillow Mask (1 per 3 mos.) _____
- Heated PAP Tubing (1 per 3 mos.)
- Nasal Pillows (2 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

☐ FULL FACE MASK KIT
- Full Face Mask (1 per 3 mos.) _____
- Heated PAP Tubing (1 per 3 mos.)
- Full Face Cushions (1 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

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: _____

www.MedicalServiceCo.com