7118 Geoffrey Way ◆ Suite P ◆ Frederick, MD 21704
Phone: 800-624-4134 Fax: 301-694-9348

# Detailed Written Order

*Duration of Prescription - 99=Lifetime*

**ORDER DATE:** _____

**Patient Name:** **Date of Birth:**

**Please select a primary diagnosis**

- ☐ G47.33 Obstructive Sleep Apnea
- ☐ G47.31 Central/Complex Sleep Apnea
- ☐ G47.37 Complex Sleep Apnea
- ☐ Other: _____

**AHI/RDI:** _____ **If AHI/RDI is LESS THAN 15, please select a secondary diagnosis below**

- ☐ G47.30 Hypersomnia with Sleep Apnea, Unspecified
- ☐ I25.9 Chronic Ischemic Heart Disease
- ☐ G47.9 Excessive Daytime Sleepiness
- ☐ G31.84 Impaired Cognition
- ☐ I10 Hypertension
- ☐ G47.00 Insomnia
- ☐ Z86.73 Hx of Stroke
- ☐ F39 Mood Disorder

| | | |
|---|---|---|
| ☐ **E0601 CPAP**<br>☐ **E0562 Heated Humidifier**<br>**CPAP Set**<br>Pressure:_____ cmH20<br>**Auto Set**<br>Auto Pap Min Pressure _____ cmH20<br>Auto Pap Max Pressure _____ cmH20 | ☐ **E0470 Bi-Level**<br>☐ **E0562 Heated Humidifier**<br>IPAP Max Pressure _____ cmH20<br>EPAP Min Pressure _____ cmH20 | ☐ **E0470 Auto Bi-Level**<br>☐ **E0562 Heated Humidifier**<br>IPAP Max Pressure _____ cmH20<br>EPAP Min Pressure _____ cmH20<br>Pressure Support Min _____ cmH20<br>Pressure Support Max _____ cmH20 |
| ☐ **E0471 Auto SV Bi-Level**<br>☐ **E0562 Heated Humidifier**<br>IPAP Max Pressure _____cmH20<br>EPAP Min Pressure _____ cmH20<br>EPAP Max Pressure _____ cmH20<br>PS Min _____ cmH2020<br>PS Max _____ cmH20<br>Rate _____ | ☐ **E0471 BIPAP AVAPS**<br>☐ **E0562 Heated Humidifier**<br>Mode: ☐ S/T ☐ T ☐ PC<br>IPAP Min Pressure _____ cmH20<br>IPAP Max Pressure _____ cmH20<br>EPAP Pressure _____ cmH20<br>VT _____ mL<br>Rate _____ BPM | ☐ **E0471 Auto ST Bi-Level**<br>☐ **E0562 Heated Humidifier**<br>IPAP Pressure _____ cmH20<br>EPAP Pressure _____ cmH20<br>Rate _____ |

***Special Instructions**

**Please check all applicable supplies:**

- ☐ *Heated Tubing (A4604) 1 per 3 month*
- ☐ *Disposable filters (A7038) 2 per 1 month*
- ☐ *Non Disposable Filter (A7039) 1 per 6 months*
- ☐ *Headgear (A7035) 1 per 6 months*
- ☐ *Chin Strap (A7036) 1 per 6 months*
- ☐ *Water Chamber (A7046) 1 per 6 months*
- ☐ *Other:* _____

**Please choose one of the following mask options**

ensuring ***all items within*** are checked.

(BP Gamma is authorized to fit patient with mask of their choice)

- ☐ *Full Face Mask (A7030) 1 per 3 months*
- ☐ *Full Face Cushion (A7031) 1 per month*

- ☐ *Nasal Mask (A7034) 1 per 3 months*
- ☐ *Nasal Cushion (A7032) 2 per month*
- ☐ *Nasal Pillows (A7033) 2 per month*

*I, the undersigned, certify that the above prescribed equipment and supplies are reasonable and necessary according to acceptable medical standards in the treatment of this condition. I confirm that this patient meets the criteria for coverage as indicated above.*

Physician Name (Printed): _____ Physician NPI: _____

Physician Signature (no stamps): _____ Date: _____