

sleeptech

phone: 503 496 5239 | fax: 503 343 6554
sleeptechnologies.com | info@sleeptechnologies.com

PRESCRIPTION

☐ Initial ☒ Renewal ☐ Revised

Diagnostic / ICD - 10 ☒ G47.33, Obstructive Sleep Apnea ☐ G47.37, Primary Central Sleep Apnea ☐ G47.30, Complex Sleep Apnea
Code: Other: _____ Initial Date: _____
Revised Date: _____ Recert Date: _____
Patient: _____ Patient Contact Number: _____
Date of Birth: _____ Patient Email Address: _____

Prognosis: ☐ Poor ☐ Fair ☒ Good Est. Length of Need (months): 99 (99 = Lifetime)

Please confirm that the following prescribed equipment is correct and complete any necessary medical information.

Equipment Prescribed:

- | | | |
|--|-------|---|
| ☐ CPAP | E0601 | Pressure: _____ cmH2O |
| ☐ Auto CPAP | E0601 | Pressure: _____ to _____ cmH2O |
| ☐ Bilevel | E0470 | IPAP: _____, EPAP: _____ |
| ☐ Auto Bilevel | E0470 | Max IPAP: _____, Min EPAP: _____, PS: _____ |
| ☐ Bilevel ST | E0471 | IPAP: _____, EPAP: _____, RR: _____ bpm |
| ☐ Bilevel ASV | E0471 | Min EPAP: _____, Max EPAP: _____, Min PS: _____, Max PS: _____, OR EPAP: _____, Min PS: _____, Max PS: _____ |
| ☐ Bilevel AVAPS | E0471 | Max IPAP: _____, Min IPAP: _____, EPAP: _____, Tidal Volume: _____ ml, RR: _____ bpm, Inspiratory Time: _____ |
| ☐ Bilevel IVAPS | E0471 | PS min: _____, PS max: _____, EPAP: _____, Target Va: _____, L/min RR: _____ bpm |

Supplies Ordered:

- | | |
|---|---|
| ☒ A7030 Full Face Mask (1x per 3 mos.) | ☒ A7038 Filter, disposable (2x per mo.) |
| ☒ A7031 Face Mask Cushion, replacement (1x per mo.) | ☒ A7039 Filter, reusable (1x per 6 mos.) |
| ☒ A7032 Nasal Mask Cushion, replacement (2x per mo.) | ☒ A7037 Tubing (1x per 3 mos.) |
| ☒ A7033 Nasal Mask Pillows, replacement (2x per mo.) | ☒ A4604 Heated Tubing (1x per 3 mos.) |
| ☒ A7034 Nasal Interface (Mask or Pillows) (1x per 3 mos.) | ☒ A7046 Water Chamber replacement (1x per 6 mos.) |
| ☒ A7035 Headgear (1x per 6 mos.) | ☒ E0562 Heated Humidifier |
| ☒ A7036 Chinstrap (1x per 6 mos.) | ☐ Substitutions permitted for CPAP supplies |

Comments (Justification): _____

Physician Name: _____ NPI#: _____

Physician Signature: _____ Date: _____

Insurance: _____

☒ CPAP Supplies ☐ New Patient Set-up ☐ Replacement Machine ☐ Pressure Change