

**Provider Order Form**



(512) 868-5044 Fax: (512) 868-1062

**Patient Information:**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Phone: \_\_\_\_\_ - \_\_\_\_\_ ICD-10 Code:  G47.33 OSA  G47.397 Central  G47.39 Other

**Referral Information:**

Facility Name: \_\_\_\_\_ Facility Contact: \_\_\_\_\_

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Order Confirmation: \_\_\_\_\_

**Sleep Therapy Equipment**

- E0601 Auto Adjusting CPAP with heated humidification at min 5cmH20 & max 20cmH20
- E0601 Auto Adjusting CPAP with heated humidification at min \_\_\_\_\_ & max \_\_\_\_\_
- E0601CPAP (/issue Auto) with heated humidification at \_\_\_\_\_
- E0470 Bilevel ( Issue Auto) with heated humidification at \_\_\_\_/\_\_\_\_
- E0470 Auto Bilevel with heated humidification with Min IPAP: \_\_\_\_\_ Max EPAP: \_\_\_\_\_ PS: \_\_\_\_\_
- E0471 ResMed ASV with heated humidification: EPAP\_\_\_\_, min PS\_\_\_\_, max PS\_\_\_\_  Auto Mode, Min EPAP\_\_\_\_, Max EPAP\_\_\_\_, Min PS\_\_\_\_, Max PS\_\_\_\_
- E0471Bilevel ST with heated humidification IPAP\_\_\_\_EPAP\_\_\_\_ Rate\_\_\_\_

**Supplies**

- Heated Humidifier E0562  Humidifier Chamber A7046 (1 every 6 months)
- Full Face Mask A7030 (1 every 3 months) / cushions A7031  Nasal Mask A7034 (1 every 3 months) / cushions A7032
- Nasal Mask A7034 (1 every 3 months) / pillows A7033
- Heated Tubing A4604 (1 every 3 months) or  Tubing A7037 (1 every 3 months)
- Disposable Filters A7038 (2 per month)  Reusable Filters A7039 (1 every 6 months)
- Headgear A7035 (1 every 6 months)  Chin Strap A7036 (1 every 6 months)
- Mask fitting to patient's comfort
- Lifetime (99 = Lifetime) or  Other \_\_\_\_\_ Months

**Referring Practitioner Certification**

Letter and Certificate of Medical Necessity: As the referring practitioner, I certify that the above prescribed order is medically necessary based on my diagnosis and is part of my overall treatment plan for my patients. In my professional opinion, the equipment and/or supplies I have prescribed for my patient is reasonable and necessary for accepted standards of medical practice and treatment of my patient's condition and has not been prescribed as "convenience equipment".

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

NPI: \_\_\_\_\_

\*Your signature confirms the accuracy of the information provided on this form