Provider Order Form

Georgetown
Sleep Equipment & Supplies

(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 humification at min 5cmH20 & max 20cmH20

☐ E0601 Auto Adjusting CPAP with heated humification 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