Physician's Prescription
Detailed Written Order

VIP Phone: 866-361-2334

VIP Fax: 888-522-6861

Please Fax The Following:
Demographics ☐ **Insurance** ☐ **Sleep Study/Testing** ☐ **F2F Initial Chart Notes**

Patient Demographics

Patient Name: **DOB:** **Gender:**

Address: **City/State:** **Zip Code:**

Home Phone: **Work Phone:** **Cell Phone:**

Primary Insurance: **ID Number:**

DX ☐ **OSA G47.33** ☐ **CSA G47.31** ☐ **CompSA G47.37** ☐ **COPD J44.9** ☐ **Hypoxemia R09.02** ☐ **Chronic Resp Faliure J96.10**

OSA - Sleep Therapy

☐ CPAP E0601 @ _____cmH20 ☐ Auto CPAP E0601: @ _____ to _____cmH20 **X** Cellular Mode

☐ Bi-Level E0470: IPAP: @_____cmH20 EPAP: @_____cmH20

☐ Auto Bi-level E0470: IPAP Max: @_____cmH20 EPAP Min: @_____cmH20 Pressure Support: _____

☐ Bi-Level W/BU Rate E0471: IPAP: @_____cmH20 EPAP: @_____cmH20 B/U Rate: _____

☐ Bi-Level ASV E0471: IPAP Max: @_____cmH20 IPAP Min:@_____cmH2O EPAP: @_____cmH20 B/U Rate: _____

☐ BIPAP AVAPS E0471: Target VT _____mL IPAP Max: @_____ EPAP Max: @_____ B/U Rate: _____

☐ Heater Humidifier E0562, due to nasal congestion

Sleep Supplies

Please note CMS guidelines only order the specific mask type listed below. If mask changes we will need to request a new DWO

☐ Full Face Mask A7030 qty 1x3mo to include all below supplies.
X Full face cushion A7031 qty 3x3mon
X Headgear A7035 qty 1x6mon
X Heated tubing A4604 qty 1x3mon
X Disp filters A7038 qty 6x3mon
X Non disp filter A7039 qty 1x6mon
X Swivel A7045 qty 1x6mon
X Water Chamber A7046 qty 1x6mon

☐ Nasal Pillow Mask A7034 qty 1x3mo to include all below supplies.
X Nasal pillow A7033 qty 6x3mon
X Headgear A7035 qty 1x6mon
X Chinstrap A7036 qty 1x6mon
X Heated tubing A4604 qty 1x3mon
X Disp filters A7038 qty 6x3mon
X Non disp filter A7039 qty 1x6mon
X Water Chamber A7046 qty 1x6mon

☐ Nasal Mask A7034 qty 1x3mo to include all below supplies.
X Nasal cushion A7032 qty 6x3mon
X Headgear A7035 qty 1x6mon
X Chinstrap A7036 qty 1x6mon
X Heated tubing A4604 qty 1x3mon
X Disp filters A7038 qty 6x3mon
X Non disp filter A7039 qty 1x6mon
X Swivel A7045 qty 1x6mon
X Water Chamber A7046 qty 1x6mon

Respiratory / Oxygen Therapy

☐ Home Oxygen Concentrator @ _____ lpm via tubing & cannula/ oxygen mask

☐ Nocturnal E1390 ☐ Bleed Oxygen into PAP ☐ 24 Hour Oxygen- Home fill/POC- E1392/K0738 Day & Night E1390

☐ Complimentary 3rd Party Overnight Oximeter Test

☐ Oxygen Testing Date: _____

☐ Oxygen Test at Rest on Room Air _____% (If ≤ 88% at rest, room air qualifies, If at rest, room air 89% > complete below tests in same session)

☐ Oxygen Testing Ambulation/walking _____% Oxygen Testing on Oxygen _____ lpm Ambulation/Walking _____%

☐ Ventilator-E0466 – Use Vent Rx form ☐ Suction Therapy w/ Vent Only-E0600

☐ Vest E0483Afflo Vest ☐ RespirTech inCourage Vest E0483 ☐ Cough-Assist E0482 ☐ Other:

Medical Necessity

The above referenced patient has an absolute ***Medical Necessity*** for the item(s) listed above. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the standards of medical practice for this patient's condition. ***The duration of the equipment/supplies will be lifetime unless otherwise indicated here:***

☐ **99** ☐ **other:**

In addition to reviewing the Sleep Study the patient has co-morbidities marked below, which require the necessary prescribed items above.

☐ Hypertension ☐ Pulmonary hypertension ☐ Ischemic heart disease history of stroke ☐ Cardiac arrhythmias

☐ Excessive daytime sleepiness Epworth scale of 10 or greater ☐ Impaired cognition or mood disorders

Ordering Physician

Physician Name: _____ NPI: _____

Address: _____ City _____ State _____ Zip _____

Telephone: _____ Fax: _____

Physician's Signature: _____ Date: _____