

# CPAP/BiPAP REFERRAL FORM

Phone: \_\_\_\_\_

**To place an order, please complete and FAX to:**

*For use in AZ and other States as applicable*

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**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**RX Date:** \_\_\_\_\_

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**Diagnosis:**     COPD (J44.9)     Central Sleep Apnea (G47.37)     Complex Sleep Apnea (G47.31)  
                   OSA (G47.33)     Hypoventilation Syndrome (E66.2)

Neuromuscular Disease Dx of \_\_\_\_\_     Other \_\_\_\_\_

Length of Need: \_\_\_\_\_ (If lifetime, use 99)

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## PAP Equipment

AHI: \_\_\_\_\_ RDI: \_\_\_\_\_

CPAP \_\_\_\_\_ CmH<sub>2</sub>O     BIPAP \_\_\_\_\_ IPAP \_\_\_\_\_ EPAP

BIPAP ST \_\_\_\_\_ IPAP \_\_\_\_\_ EPAP \_\_\_\_\_ Back-up Rate

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## PAP Supplies

- |  |   |
|--|---|
| <input type="checkbox"/> A4604 Tubing, Heated (1 per 3 months)         | <input type="checkbox"/> A7034 Nasal Mask (1 per 3 months)          |
| <input type="checkbox"/> A7027 Oral/Nasal Mask (1 per 3 months)        | <input type="checkbox"/> A7035 Headgear Device (1 per 6 months)     |
| <input type="checkbox"/> A7028 Oral Cushion (2 per month)              | <input type="checkbox"/> A7036 Chinstrap Device (1 per 6 months)    |
| <input type="checkbox"/> A7029 Nasal Pillows (2 per month)             | <input type="checkbox"/> A7037 Tubing, CPAP (1 per 3 months)        |
| <input type="checkbox"/> A7030 Full Face Mask (1 per 3 months)         | <input type="checkbox"/> A7038 Filter, Disposable (2 per month)     |
| <input type="checkbox"/> A7031 Face Mask Interface (1 per month)       | <input type="checkbox"/> A7039 Filter, Non-Disposable (1 per 6 mos) |
| <input type="checkbox"/> A7032 Nasal Cushion Replacement (2 per month) | <input type="checkbox"/> A7046 Humidifier Chamber                   |
| <input type="checkbox"/> A7033 Nasal Pillow Replacement (2 per month)  | <input type="checkbox"/> E0562 Heated Humidifier                    |
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## Respiratory Services

RT Evaluation     CPAP/Bi-PAP Supplies/Mask Fitting

Overnight Oximetry to be performed on:

Room Air     Oxygen at \_\_\_\_\_ LPM     CPAP/BiPAP/APAP     CPAP/BiPAP w/ Oxygen at \_\_\_\_\_ LPM

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## Comments/Other Orders:

**Please provide a copy of sleep study and face-to-face chart notes prior to sleep study with the order**

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I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

Physician's Printed Name: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Signature Date: \_\_\_\_\_

**Medicare requires the Signature and Signature Date be completed by a PECOS enrolled MD, DO, PA, NP, or CNS**