

CPAP/BiPAP REFERRAL FORM

For use in NV

Patient Name: _____

Date of Birth: _____

RX Date: _____

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)

PAP Equipment

AHI: _____ RDI: _____

CPAP _____ CmH₂O BIPAP _____ IPAP _____ EPAP

BIPAP ST _____ IPAP _____ EPAP _____ Back-up Rate

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 |

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

Comments/Other Orders:

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

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