CPAP/BIPAP Rx

R&M Reyes Enterprise, LLC

R&M Reyes Associate	**Phone** 808-676-7661
Branch Location	**Fax** 808-442-9218

REFERRING PHYSICIAN/CLINIC

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Home phone _____ Mobile phone _____

Documents Required

- Copy of patient demographics and insurance information
- Face-to-face evaluation/patient chart notes documenting signs and symptoms of OSA, signed and dated prior to sleep study
- Completed sleep study signed and dated by either an appropriately sleep accredited physician or an active staff physician of an accredited sleep center/laboratory
- For Bi-level device only: all required documentation listed in this section must be provided and a) evidence to support that an E0601 positive airway pressure device (CPAP) has been tried and proven ineffective based on a therapeutic trial conducted either in a facility or in a home setting; and b) documentation in the medical record must include reference to the patient's failure to meet therapeutic goals using a CPAP during the titration portion of a facility-based study or during home use despite optimal therapy

PAP Ordered

Select ONE only:

☐E0601 CPAP_____ cmH20 (4-20 cmH20) Ramp time _____ min(s) (OFF-45 min) OR ☐ Check box to adjust to patient comfort

☐E0601 Auto Adjusting CPAP with settings of 4-20 cmH20 with comfort settings MIN PRESSURE_____ MAX PRESSURE_____

☐ E0601 Auto Adjusting CPAP with settings of _____ cmH20 to_____ cmH20 with comfort settings (4-20 cmH20)

☐ E0470 BiPAP Settings: IPAP_____ EPAP_____ S/T BACK UP RATE_____

☐ E0470 Auto BiPAP MIN EPAP_____ MAX IPAP_____ FLEX/EPR EQUIVALENT LEVEL_____

☐ E0470 Auto Adjusting 5V Bi-level: Max Pressure_____Max EPAP_____ cmH20 Min EPAP _____ cmH20*
Max Pressure Support PS_____ (0-10 cmH20) Min Pressure Support _____ Back Up Rate_____ Rise Time_____ BiFlex_____
RAMP_____Minutes or _____ Set to Patient Needs

Diagnosis ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's chart notes. Please check the appropriate diagnosis or write in the code and description. Ranges will not be accepted.

☐ G47.33 Obstructive Sleep Apnea (OSA) (Adult and Child) ☐ Other _____

☐ Secondary condition (if AHi/ROi is 5-14) _____

Estimated length of need _99_ **months (99=lifetime)** ☐ E1390 Oxygen; bleed in at_____LPM

Supplies Ordered (Maximum Quantities Allowed per Medicare Guidelines)

Select ONE only: ☐ E0561 Humidifier (non-heated) **OR** ☐ E0562 Humidifier (heated)

(Maximum quantities allowed per Medicare guidelines)

EPR OF 3

Check ONLY those that apply (mask or pillows):

☐ A7027 Oral/Nasal mask (1x3 mo)
☐ A7028 Oral cushion (2x1 mo)
☐ A7029 Nasal pillows (2x1 mo)
☐ A7030 Full face rnask (1x3 mo)
☐ A7031 Full face mask interface (1x1 mo)
☐ A7032 Face mask cushion/seal (2x1 mo)
☐ A7033 Pillows (2x1 mo)
☐ A7034 Mask (1x3 mo)
☐ A7044 Oral face mask
☐ Mask: Patient preference_____

Check ALL that apply:

A7035 Headgear (1x6 mo)
☐ A7037 Tubing (1x3 mo)
☐ A7038 Disposable filters (2x1 mo)
☐ A7039 Non-disposable filters (1x6 mo)
☐ A7046 Water chamber for humidifier (1x6 mo)
☐ A4604 Tubing w/heating element (1x3 mo)*********
☐ A7036 Chinstrap (1x6 mo)
☐ A7045 Exhalation port

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the item(s) prescribed.

Print prescriber's name _____ **NPI #** _____

Prescriber signature _____ **Date** _____