CHOICE medical equipment
1173 Bent Oaks Dr, Denton, TX, 76210
(PH) 940-380-0455
(FX) 940-382-3026

CPAP / BIPAP - DETAILED WRITTEN ORDER

Patient:_____DOB:_____Date:_____

Address: _____Phone:_____

Estimated LON: 99 Months (Lifetime) unless otherwise specified_____

PATIENT DIAGNOSIS (ICD-10) – AT LEAST ONE MUST BE CHECKED

- ☐ G47.33 Obstructive Sleep Apnea
- ☐ G47.31 Primary Central Sleep Apnea
- ☐ G47.37 Central Sleep Apnea/Complex Sleep Apnea
- ☐ Other_____

SLEEP THERAPY:

- ☐ CPAP (E0601) _____cmH2O
- ☐ CPAP - Auto Titrating (E0601) Min: _____cmH2O Max:_____cmH2O
- ☐ BIPAP (E0470) IPAP:_____cmH2O EPAP:_____cmH2O
- ☐ RAD with Backup (E0471) EPAP:_____cmH2O
  IPAP Min:_____cmH2 IPAP Max:_____cmH2O
  Back up Rate: _____ Inspiratory Time: _____
- ☐ Heated Humidifier (E0562)

DISPOSABLES: (Mark all that apply.)

- ☐ Chinstrap – 1 per 6 mo (A7036)
- ☐ H2O Chamber – 1 per 6 mo (A7046)
- ☐ Headgear – 1 per 6 mos (A7035)
- ☐ Filter: Non Disp – 1 per mo (A7039)
- ☐ Filter: Disp – 2 per mo (A7038)

FULL FACE MASK:

- ☐ Full Face Mask – 1 per 3 mo (A7030)
- ☐ Full Face Cushion – 1 per mo (A7031)
- ☐ Hybrid Mask – 1 per 3 mo (A7027)

NASAL MASK:

- ☐ Nasal Mask – 1 per 3 mo (A7034)
- ☐ Nasal Pillows – 2 Pair per mo (A7033)
- ☐ Nasal Cushion – 2 per mo (A7032)

TUBING:

- ☐ Tubing – 1 per 3 mo (A7037) -OR- ☐ Climate Line – 1 per 3 mos (A4604)

- ☐ **OTHER: (PLEASE SPECIFY)** _____

PLEASE ATTACH THE FOLLOWING AS APPLICABLE:

- ☐ Test Results (Oximetry, ABG, Sleep Study)
- ☐ Patient Demographics Sheet
- ☐ Copy of Patient's Insurance Card
- ☐ Physician's Notes Notes from the patient's medical record documenting face-to-face equipment needs assessment and expected benefit from equipment ordered above.

PHYSICIAN INFORMATION:

Name:_____ NPI:_____ Phone: _____

Address: _____ Fax:_____

Physician Signature: _____ Date: _____