HOME medical SUPPLY

Tel: 919.522.5221
Fax: 919.874.5123
homedicalsupply.com

☐ Private Insurance: _____
☐ Medicaid ☐ Medicare ☐ Self Pay
Policy #_____

CPAP / BIPAP & TRACH ORDER FORM

Patient Name:_____**Date of Birth:**_____**RX Date:**_____

Diagnosis: ☐ COPD (496.) ☐ Central Sleep Apnea (327.27) ☐ Complex Sleep Apnea (327.21)
☐ OSA (327.23) ☐ Hypoventilation Syndrome (278.03)

☐ 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

☐ A4604 Tubing, Heated(1 per 3 months)
☐ A7027 Oral/Nasal Mask (1 per 3 months)
☐ A7028 Oral Cushion (2 per month)
☐ A7029 Nasal Pillows (2 per month)
☐ A7030 Full Face Mask (1 per 3 months)
☐ A7031 Face Mask Interface (1 per month)
☐ A7032 Nasal Cushion Replacement(2 per month)
☐ A7033 Nasal Pillow Replacement (2 per month)
☐ A7034 Nasal Mask (1 per 3 months)
☐ A7035 Headgear Device (1 per 6 months)
☐ A7036 Chinstrap Device (1 per 6 months)
☐ A7037 Tubing, CPAP (1 per 3 months) A7038
☐ Filter, Disposable (2per month) A7039 Filter,
☐ Non-Disposable (1 per 6mos)
☐ A7046HumidifierChamber
☐ E0562 Heated Humidifier

TRACHEOSTOMY SUPPLIES:

Diagnosis: ☐ Z93.0 – Tracheostomy Status ☐ Z43.0 Attention to Tracheostomy ☐ Other _____
☐ D02.0 – CA In Situ Larynx ☐ D02.1 – CA In Situ Trachea ☐ Prognosis_____

☐ Suction Machine (E0600) ☐ Suction Tubing (A7002)
Suction Cannister ☐ A7000 Disposable *qty*_____ ☐ A7001 Non-disposable *qty*_____
☐ Suction Catheter (A4624) – French: _____ (Trach) ☐ Suction Catheter Kit (A4628) – French: _____ (Oral Suction)
Normal Saline ☐ A4216 10 ml ☐ A4217 500 ml
Inner Cannula (Shiley) (A4622) ☐ Larynectomy ☐ Tracheostomy Size: _____
☐ Disposable ☐ Cuffless ☐ Cuffed ☐ Fenestrated

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

THANK YOU FOR YOUR REFERRAL ORDER!