CPAP Services
THE FINEST IN QUALITY SLEEP RELATED EQUIPMENT

San Jose Office: 75N. Bascom Ave. Suite 120, San Jose, CA 95128 | Phone (408) 627-7184
Monterey Office: 60 Garden Ct., Suite 200, Monterey, CA 93940 | Phone (831) 233-3130

IN-TAKE PRESCRIPTION

FAX ORDER TO:
San Jose Office: (408) 292-CPAP (2727)
Monterey Office: (831) 886-3665

Patient Name: _____ (Last / First / MI) Date of Service: _____

Patient Address: _____ (Street / City/ State / Zip Code) DOB: _____

Patient Phone Number: ( ) _____-_____ (Home) ( ) _____-_____ (Cell)

Diagnosis: ❑ OSA (G47.33) ❑ COPD (J44.9) ❑ Emphysema (J44.1) ❑ CHF (ISO.9) ❑ Respiratory Failure (J96.20) ❑ ALS (680.9) ❑ Other: _____

NEW EQUIPMENT ORDERED:

❑ **CPAP (E0601)** @: _____CmH2O ❑ **Auto-CPAP (E0601)** @:_____-_____CmH2O

❑ **Bi-Level (E0470)** @: _____/_____CmH2O

❑ **Auto Bi-Level (E0470)** EPAP Min@: _____ IPAP Max@: _____CmH2O

❑ **Bi-Level ST (E0471)** IPAP@: _____EPAP@: _____ Rate@: _____

❑ **ASV (E0471)** EPAPmin: _____ EPAPmax: _____ PSmin: _____ PSmax: _____ IT: _____

Comfort Setting (A-Flex/EPR) _____ Ramp time _____min

❑ **Heated Humidifier (E0562)** ❑ **Chinstrap (A7036)** Duration/Estimated Length of Need: **99** **= Lifetime**

OTHER SERVICES:

❑ Overnight Oximetry Study

❑ **OXYGEN (E1390)** ❑ Nocturnal ❑ Continuous (24hrs)@ _____ Lpm. ❑ Per nasal cannula ❑ Bleed-in

❑ Coordinate Sleep Study (PSG)

❑ **NIV (Non-Invasive Ventilator) (E0464)**

SUPPLIES: For PAP Device: _____

HCPCS	DESCRIPTION / FREQUENCY	HCPCS	DESCRIPTION / FREQUENCY
❑ A7030	Full Face Mask (1 per 3 months) No Headgear	❑ A4604	Heated Tubing (1 per 6 months)
❑ A7031	Full Face Interface (Cushion) (1 per month)	❑ A7038	Disposable filter (2 per month)
❑ A7034	Nasal or Pillows **Mask** (1 per 3 months)	❑ A7039	Non-Disp. Filter (1 per 6 months)
❑ A7033	Nasal pillow (2 per month)	❑ A7035	Headgear (1 per 6 months)
❑ A7032	Nasal cushion (2 per month)	❑ A7036	Chinstrap (1 per 6 months)
❑ A7037	Standard Tubing (1 per 3 months)	❑ A7046	Humidifier Chamber/Tub (1 per 6 months)

❑ Please Fit Mask/Patient Comfort: _____
Or Please Specify Mask

Physician Name: _____ **NPI:** _____

Address: _____ (Street / City/ State / Zip Code)

Telephone Number: ( ) _____-_____ Fax Number: ( ) _____-_____

I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

Physician's Signature: _____ **Date:** _____