Everything CPAP

Durable Medical Equipment Order Form

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Boise, Idaho 83704
Ph 208.323.2727
Fx 208.323.1615

Patient Demographics

Patient name: _____ Prescription date: _____

DOB: _____ Length of Need: _____

Diagnosis/ICD10 (circle all that apply):

G47.33 obstructive sleep apnea adult, pediatric **G47.30** Hypersomnia with sleep apnea **G47.10** hypersomnia

G47.37 Central sleep apnea; conditions classified elsewhere **G47.31** primary central sleep apnea **R09.02** hypoxemia

Prescription

Machine/model: _____ Mask: _____

❑ **CPAP** set to _____ cmH_2O

❑ **Auto-Titrating CPAP** (minimum)_____ cmH_2O to (maximum) _____ cmH_2O

❑ **Overnight Oximetry**

❑ **Supplies** Interface (1 per 3 mo.) Headgear (1 per 6 mo.) Heated tube (1 per 3 mo.)

Humidifier chamber (1 per 6 mo.) Chinstrap (1 per 6 mo.) Non-Heated tube (1 per 3 mo.)

Replacement cushion/pillow (2 per mo.) Disposable filter (2 per mo.) Reusable filter (1 per 6 mo.)

Replacement cushion full face mask (1 per mo.)

Comments

I certify that the above prescription is medically necessary.

Provider: _____

Signature: _____

Date: _____

Fax completed form to 208.323.1615

For new patients kindly include the following:

- ✓ Sleep study
- ✓ Patient history/ progress notes
- ✓ Registration information