DOUBEK medical supply

TF: 800.368.2358
F: 708.293.1144
doubekmedical.com

Referral Name: _____

Referral #: _____

Fax to (708) 293-1144

CPAP/BiPAP Written Order

PATIENT INFORMATION

Order Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Email Address: _____ Phone #: _____

Diagnosis: ☐ G47.33 Obstructive Sleep Apnea ☐ G47.31 Central Sleep Apnea (Needed to qualify for ASV or Adapt-E0471) ☐ Other: _____

Duration: ☐ Lifetime (99) ☐ Other: _____

PATIENT INSURANCE INFORMATION

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance _____

Insurance ID #: _____ Group # _____

It is not necessary to fill it out this section, if the order is accompanied by a copy of the patient's insurance card.

PAP DEVICE *(select one and indicate settings)*

Cpap (E0601) ☐ _____ cwp ☐ EPR/CFlex _____

Auto Cpap (E0601) ☐ _____ to _____ cwp

If a Bilevel is being ordered, has the cpap been tried and proven ineffective based on a therapeutic trial? ☐ Yes ☐ No

Bilevel (E0470) ☐ IPAP _____ cwp, EPAP _____ cwp

Bilevel Auto (E0470) ☐ IPAP max. _____ cwp, EPAP min. _____ cwp. PS _____

Bilevel ST (E0471) ☐ IPAP _____ cwp, EPAP _____ cwp, Breathing Rate of _____/minute.

Resmed VPAP Adapt (E0471) ☐ EEP _____ cwp PS min _____ PS max _____

Resmed VPAP Adapt Auto (E0471) ☐ EEP min _____ max _____ PS min _____ PS max _____

Humidifier *(select one)*
- ☐ Heated (E0562)
- ☐ Cool (E0561)

Tubing *(select one)*
- ☐ Heated (A4604) 1/3 months
- ☐ Standard (A7037) 1/3 months

Filters *(select all that are required)*
- ☐ Disposable (A7038) 2/month
- ☐ Non-Disposable (A7039) 1/6 month

MASK OPTIONS - Select Full, Nasal or Pillows *(Order must only be for one mask type. Submit an additional order for other mask types.)*

Full Face Mask *(select all if the full face mask is ordered)*
- ☐ Mask (A7030) 1/3 months
- ☐ Repl Cushion (A7031) 2/month
- ☐ Headgear (A7035) 1/6 months

Nasal Mask *(select all if the nasal mask is ordered)*
- ☐ Mask (A7034) 1/3 months
- ☐ Repl Cushion (A7032) 2/month
- ☐ Headgear (A7035) 1/6 months

Nasal Pillows *(select all if the nasal pillows mask are ordered)*
- ☐ Mask (A7034) 1/3 months
- ☐ Repl Pillows (A7033) 2 set/month
- ☐ Headgear (A7035) 1/6 months

☐ Sleep Study Attached ☐ Face to Face Attached

If the patient is currently receiving oxygen therapy, please complete: Nocturnal Oxygen Bleed In _____ LPM

PRESCRIBING PHYSICIANS INFORMATION

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Physician Phone #: _____ Fax #: _____