Sound Oxygen Service
CPAP/ BiPap/ ST-ASV Order Process:

1. **Complete the Rx form below**

2. **Attach-**

    a. **Initial Consultation Notes dated before the Sleep Study**
    b. **Sleep Study**
    c. **Sleep Study interpretation**
    d. **Demographics**
    e. **Insurance Information**

3. **Fax the above information to – 877.519.8723**

Positive Airway Pressure (PAP) Prescription

Sound Oxygen Service
Sleep•Breathe•Live

Patient's First Name: _____ Last Name: _____ DOB: _____

DIAGNOSIS (Please check all that apply)

☐ **G47.33** OSA (Obstructive Sleep Apnea) ☐ **G47.31** Primary Central Sleep Apnea ☐ **G47.30** Sleep Apnea unspecified
☐ **G47.37** Central Sleep Apnea in Conditions Classified Elsewhere ☐ Other DX Code/s: _____

Length of need: _____ months (Enter 99 for lifetime need)

DEVICE: (please indicate if this is ☐ **NEW** or ☐ **Replacement**)

☐ **CPAP/APAP (E0601)**: CPAP+_____cmH2O: APAP Start Pressure Min/Max _____ /_____ cmH2O APAP max _____ cmH2O

☐ **BiLevel/BiLevel Auto (E0470)**: Pressures: EPAP Min _____ IPAP max _____PS: min/max _____/_____

☐ **ASV–BiLevel S/T (E0471)**: EPAP min: _____ EPAP max _____ IPAP min _____ IPAP max _____ PS min _____ PS max _____ BPM _____ /Auto

☐ **AVAPS (E0471)**: EPAP _____ IPAP min _____IPAP max _____ BUR _____ Target Vt: _____ ml (calc value= 7-10ml/kg ideal body weight)

☐**O2 Bleed-In @_____ LPM** ☐ **SpO2 < /= 88% for 5 minutes or more while OSA controlled** (Additional documents may be required)

☐ **Heated Humidifier (E0562)**

SUPPLIES: (please indicate if this is a ☐ **NEW** or ☐ **Established** patient)
☐ Patient preference (if selected a detailed written order will be forwarded for your signature)
OR
☐Selected CPAP Mask/Interface/Delivery System below:
(*) Replacement schedule based on Medicare allowable. Individual insurance policy replacement schedule may vary.

Nasal Mask	Oral Mask
☐ 1Each **A7034 Nasal Application Device** (*1 per 3 months) ☐ 6 Each **A7032 Replacement Cushion** (*6 per 3 months) ☐ 6 Each **A7033 Replacement Pillows** (*6 per 3 months) ☐ 1 Each **A7035 Headgear** (*1 per 6 months)	☐ 1 Each **A7044 Oral Interface** (*1 per 6 months) ☐ 1 Each **A7035/A9999 Headgear** (*1 per 6 months) ☐ **Other _____**

Full Face Mask	Hybrid Oral / Nasal Mask
☐ 1 Each **A7030 Full Face Mask** (*1 per 3 months) ☐ 3 Each **A7031 Full Face Mask Cushion** (*3 per 3 months) ☐ 1 Each **A7035 Headgear** (*1 per 6 months) ☐ 1 Each **Other _____**	☐ 1 Each **A7027 Mask** (*1 per 6 months) ☐ 1 Each **A7028 Replacement Cushion** (*6 per 3 months) ☐ 1 Each **A7029 Replacement Pillows** (*6 per 3 months) ☐ 1 Each **A7035 Headgear** (*1 per 6 months)

Miscellaneous (select all that apply)

☐ 1 Each **A4604 Heated Tubing** (*1 per 3 months)	☐ 1 Each **A7036 Chin Strap** (*1 per 6 months)
☐ 1 Each **A7037 Standard Tubing** (*1 per 3 months)	☐ 6 Each **A7038 Disposable Filters** (*6 per 3 months)
☐ 1 Each **A7046 Replacement Humidifier Chamber** (*1 per 6 months)	☐ 1 Each **A7039 Non-Disposable Filters** (*1 per 6 months)

Physician Information:

Physicians Name (PRINT): _____ **NPI #:** _____

Physician Signature: _____ **Date:** _____