PAP THERAPY PRESCRIPTION

Patient's Name: _____ Date of Birth: _____

Address: _____

Diagnosis Code: □ G47.33 Other: _____ AHI/RDI: _____Minimum O_2 Saturation _____%

Start Date: _____ Length of Need: □ Lifetime □ Other:_____

Prescribed Service(s)

Device Type: □ CPAP (E0601) □ A-PAP (E0601) Bi-PAP (E0470) □ V-PAP (E0470)

Pressure Settings CPAP:_____ cm H_2O; A-PAP:_____ cm H2O

Bi-PAP: IPAP _____cm H2O, EPAP _____ cm H2O

Ramp: _____ C-flex: _____ EPR: _____

Supplemental O_2 : _____L/M

PAP Device Supplies and Accessories

- ☑ E0562 Humidifier, heated

Fit for Comfort

- ☑ A7030 Full face mask, 1 per 3 months
- ☑ A7031 Face mask interface, replacement for full face mask, 1 per 1 month
- ☑ A7032 Cushion for use on nasal mask interface, replacement only, 2 per 1 month
- ☑ A7033 Pillow for use on nasal cannula type interface, replacement only, 2 per 1 month
- ☑ A7034 Nasal interface (mask or cannula type), 1 per 3 months
- ☑ A7035 Headgear 1 per 6 months
- ☑ A7036 Chinstrap, 1 per 6 months
- ☑ A7037 Tubing, 1 per 3 months
- ☑ A4604 Tubing with integrated heating element, 1 per 3 months
- ☑ A7038 Filter, disposable, 2 per 1 month
- ☑ A7039 Filter, non-disposable, 1 per 6 months
- ☑ A7046 Water chamber for humidifier, 1 per 6 months

STATEMENT OF MEDICAL NECSSITY: The above named patient has undergone clinical evaluation and sleep study/polysomnography confirming the diagnosed as indicated. Due to potentially dangerous consequences of disturbed sleep and sleep deprivation, PAP therapy is indicated. The prescribed treatment is medically necessary. Without therapy, patient's condition will deteriorate presenting a major threat to the patient's health.

_____ _____

Authorized Signature **Date**

_____ _____

Print Name **NPI**

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