CPAP CARE CENTERS
Sleep Apnea Supplies

PHYSICIAN ORDER FORM:
THIS SERVES AS A PRESCRIPTION

(Please fax completed Order, Insurance ID and Sleep Study Report)

PATIENT NAME: ____DOB: _________________________

ADDRESS: ____CITY, STATE, ZIP: ____

TEL NO(S): ____EMAIL: ____

INSURANCE: ____ ID NO: ____

CPAP/AUTOS/BI-PAP

☐ **CPAP** at ___________cm/H2O
☐ **Bi-PAP** at _____/_____cm/H2O
☐ **Auto-CPAP** (4-20cm H20) _____/_____cm/H2O
☐ **Auto-SV**
☐ **Oral Appliance**

Length of Need: ________ (99 months= lifetime)

SUPPLIES

☐ *Mask (list type if known) ____*
☐ *Mask Per Patient Comfort (requires fitting)*
☐ *Cushions*
☐ *Tubing*
☐ *Filters*
☐ *Humidifier*
☐ ***New CPAP If current CPAP is more than 3 years old (most patients qualify)***

DIAGNOSIS

☐ G47.33 Obstructive Sleep Apnea ☐ G47.31 Primary Central Sleep Apnea (includes complex sleep apnea)
☐ R06.3 Cheyenne- Strokes Breathing Problem ☐ Other: ____

REFERRING PHYSICIAN

NAME: ____NPI: ____

TEL: ____FAX: ____

SIGNATURE: ____DATE: ____

TEL: (800) 647-0314 **FAX: (800) 647-0315**