CPAP/BiPAP Referral Form

For use in NV

Patient Name: **Date of Birth:** **RX Date:**

Diagnosis: ☐ COPD (J44.9) ☐ Central Sleep Apnea (G47.37) ☐ Complex Sleep Apnea (G47.31)
☐ OSA (G47.33) ☐ Hypoventilation Syndrome (E66.2)

☐ Neuromuscular Disease Dx of _____ ☐Other _____

Length of Need: _____ (If lifetime, use 99)

PAP Equipment

AHI: _____ RDI: _____

☐ CPAP _____ CmH_2O ☐ BIPAP _____ IPAP _____ EPAP

☐ BIPAP ST_____ IPAP _____ EPAP _____ Back-up Rate

PAP Supplies

☐ A4604 Tubing, Heated (1 per 3 months)
☐ A7027 Oral/Nasal Mask (1 per 3 months)
☐ A7028 Oral Cushion (2 per month)
☐ A7029 Nasal Pillows (2 per month)
☐ A7030 Full Face Mask (1 per 3 months)
☐ A7031 Face Mask Interface (1 per month)
☐ A7032 Nasal Cushion Replacement (2 per month)
☐ A7033 Nasal Pillow Replacement (2 per month)
☐ A7034 Nasal Mask (1 per 3 months)
☐ A7035 Headgear Device (1 per 6 months)
☐ A7036 Chinstrap Device (1 per 6 months)
☐ A7037 Tubing, CPAP (1 per 3 months)
☐ A7038 Filter, Disposable (2 per month)
☐ A7039 Filter, Non-Disposable (1 per 6 mos)
☐ A7046 Humidifier Chamber
☐ E0562 Heated Humidifier

Respiratory Services

☐ RT Evaluation ☐CPAP/Bi-PAP Supplies/Mask Fitting

☐ Overnight Oximetry to be performed on:

☐ Room Air ☐ Oxygen at___ LPM ☐ CPAP/BiPAP/APAP ☐CPAP/BiPAP w/ Oxygen at ____ LPM

Comments/Other Orders:

Please provide a copy of sleep study and face-to-face chart notes prior to sleep study with the order

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

Physician's Printed Name: NPI: Fax:

Physician's Signature: Signature Date:

Medicare requires the Signature and Signature Date be completed by a PECOS enrolled MD, DO, PA, NP, or CNS