

Physician's Order
CPAP and Supplies

Date: _____ New Patient: yes / no Replacement equipment only

Patient: _____ DOB: __/__/__
(First/Middle/Last)

Address: _____ City: _____ State: ____ Zip: _____

Phone: Hm(____) _____ Mobile (____) _____

Questions Reviewed:	Answers:
Diagnosis of Patient? 327.23 (OSA), 327.2 (Other Unspecified), 327.27 (CSA) 780.53 (Hypersomnia w/sleep Apnea)	ICD9:
Estimated Length of Need/mo? 1-99 (99=Lifetime)	_____/mo.

Durable Medical Supplies (PAP) supplies: **Oxygen** _____ lpm flow. Conserving Device: _____ yes/no

CPAP Heated/Humidifier Patient's Preference CPAP/Supplies:(mask/tubing/filters nasal interface, etc.)

Pressure Setting: _____ cm Auto Setting: _____ cm Mask: Nasal mask
Range (Min/Max) Full Face Nasal Pillows

Bi-Pap Heated/Humidifier Patient's Preference Patient's Preference

Pressure Setting: Insp. Pressure _____ cm Exhal. Pressure _____ cm Max PS: _____

Supplies used with PAP: Mask (A7027,A7030,A7034) Tubing (A7037, A4604)
Headgear (A7035), Chinstrap (A7036), Non-disp filter (A7039), Repl chamber (A7046)
Repl mask interface (A7031), Disposable filters (A7038)
Repl cushion, ea (A7032, A7028), Repl pillows, pair (A7033, A7029)

Print Name of Ordering Physician: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____ NPI# _____

Physician's Signature: _____ Date: _____



Division of Medical Direct LLC.
21222 30th Drive SE. Suite 210
Bothell, Wa. 98021-7069
Toll free:1-877-272-7626
Fax: **888-236-0407**
e-mail: support@cpapman.com

Physician Consent Form for

Durable Medical Equipment/PAP Supplies

Physician:

Your patient is requesting new & replacement CPAP/Bipap supplies for their sleep apnea therapy. Please authorize Medical Direct LLC (The CPAP Store) to dispense these items by completing the following consent/authorization form.

The FDA requires all CPAP patients have at least a yearly or updated prescription for CPAP supplies (Mask) or New replacement CPAP machine.

Thank you,