Physician's Order – Continuous Positive Airway Pressure (CPAP)

Patient Information:	
Name:	
Address:	
City, State, Zip	
Responsible Party	
HIC#	
DOB	
Height:	
Weight:	

Provider Information:
Professional Medical Home Healthcare
4859-C Memorial Drive
Stone Mountain, GA 30083
404-292-9190
404-508-9225 Fax
NPI XXXX287131

Diagnosis _____ Description _____ Length of Need: ____ Months ___ Lifetime

Please answer the following questions:

Yes No 1. Was a sleep study of at least 2 hours in duration performed on the patient?

Yes No 2. Did the patient have at least an AHI w/ 15 events per hour?

Yes No 3. Did the patient have an AHI between 5 and 14 events per hour with one of the following documented:

{ } Excessive daytime sleepiness
{ } Impaired cognition
{ } Mood disorders
{ } Insomnia
{ } Hypertension
{ } Ischemic heart disease
{ } History of stroke

Yes No 4. For a Bi-Level, has CPAP been tried and proven ineffective?

CPAP Setting: _____cmH20

Auto CPAP Setting: _____cmH20

Bilevel Unit S/ST Setting _____ IPAP ____ EPAP ____ Rate

Answer the following only after 31 days of CPAP use but no later than the 91 st day of use.

Yes No 1. Did the patient indicate compliance with the device (defined as using CPAP >= 4 hours per night on at least 70% of nights in a consecutive 30-day period)?

Yes No 2. Did the patient demonstrate improvement in symptoms of obstructive sleep apnea with use of CPAP?

Yes No 3 Date verified:_____

Based upon the above information, the following items are needed by this patient for the stated length of need:

Date Needed	Quantity	HCPC	Description
_____	1.00	E0601 RR KH	CPAP
_____	1.00	A7035 NU KX	HEAD GEAR
_____	1.00	A7037 NU KX	TUBBING
_____	1.00	A7035 NU KX	MASK
_____	1.00	E0470 NU KX	BIPAP

1. the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment For this patient. The need and medical necessity for the above listed equipment and/or supplies is documented in the patient's medical record and is available upon request.

_____ Physician Signature

_____ Date

Physician Name:	
Address:	
City, State, Zip	

NPI Number
Phone Number:
Fax Number: