CPAP / BI-LEVEL ORDER FORM

Please return completed form with patient's face sheet & applicable clinical notes to the e-mail at the bottom of this page

Patient Name:	**Height:** _____ **Weight:** _____
Date of Birth: _____ /_____ /_____ ☒M ☐F	**Diagnosis:** ☐ Obstructive Sleep Apnea (G47.33) ☐ Idiopathic Hypersomnia (G47.11) ☐ Central Sleep Apnea (G47.37) ☐ Narcolepsy (G47.419) ☐ Periodic Limb Movement Disorder (G47.61) ☐Other: _____ ; _____
Address: _____ _____	
Primary Insurance:	**ID:**
Secondary Insurance:	**ID:**
Order Start Date:	

EQUIPMENT TYPE

E0601 ☐CPAP _____ cm H_2O FLEX/EPR___ (1, 2 or 3)
E0601 ☐CPAP AUTO :_____ to _____ cm H_2O FLEX/EPR___ (1, 2 or 3)
E0470 ☐BI-LEVEL: IPAP_____ cm H_2O EPAP:_____ cm H_2O FLEX/EPR___ (1, 2 or 3))
E0471 ☐BI-LEVEL W/ BACK-UP RATE: IPAP_____ cm H_2O EPAP:_____ cm H_2 RATE_____ FLEX/EPR___ (1, 2 or 3)

MASKS

A7030 ☐ FULL FACE MASK (1 PER 3 MONTHS)
A7034 ☐NASAL MASK (1 PER 3 MONTHS)
A7034 ☐NASAL PILLOW MASK (1 PER 3 MONTHS)
A7027 ☐COMBO MASK (ORAL/NASAL) (1 PER 3 MONTHS)

SUPPLIES

A7035 ☐HEADGEAR (1 PER 6 MONTHS)
A7036 ☐CHINSTRAP (1 PER 6 MONTHS)
A7037 ☐TUBING (1 PER 3 MONTHS)
A7038 ☐FILTER, DISPOSABLE (2 PER MONTH)
A7039 ☐FILTER, NON-DISPOSABLE (1 PER 6 MONTHS)
E0562 ☐HEATED HUMIDIFER (1 EVERY 5 YEARS)
A7046 ☐HUMIDFIER CHAMBER (1 PER 6 MONTHS)

Ordering Physician Information

Ordering Physician Name: (Print) _____	**Address:** _____ _____	**Phone #:** **Fax #:**
Ordering Physician Signature **X**_____	**Date:** _____ / _____ / _____	**NPI #:** **PECOS REGISTERED? ☐ Y / ☐ N**

***NOTE TO PHYSICIAN: THIS FORM WAS FILLED OUT ACCORDING TO INFORMATION WE RECEIVED FROM YOUR OFFICE AND/OR YOUR PATIENT. BY SIGNING THIS FORM YOU ARE CERTIFYING THAT YOU HAVE REVIEWED IT FOR ACCURACY AND THERE IS SUPPORTING DOCUMENTATION VERIFYING THIS INFORMATION IN THE PATIENTS PERMANENT MEDICAL RECORDS AND THAT INFORMATION IS AVAILABLE UPON REQUEST.**

SEND COMPLETED FORM TO: eric@domehc.com

PLEASE CALL 347-831-1013 WITH ANY QUESTIONS