CPAP MEDICAL
MILITARY SLEEP THERAPY

PRESCRIPTION/CMN

Patient Information

Full Name: _____
Date of Birth: _____
Phone number(s): _____
Address: _____
_____
City, State & Zip: _____

Primary Insurance Information

Insurer Name: _____
Insured Number: _____

Prescription Information

✓ Select a diagnosis: ☐ OSA G4733 ☐ CSA G4737
Optional Diagnosis: _____
Length of need (99=lifetime): _____ months

✓	Device	HCPCS	Device Settings				
☐	CPAP* or Autopap*	E0601	Pressure: _____	Provide a pressure range, if Autopap prescribed			
☐	BiPAP*	E0470	IPAP: _____	EPAP: _____			
☐	Resmed VPAP Auto*	E0470	Max IPAP: _____	Min EPAP: _____	PS: _____		
☐	BiPAP Auto*	E0470	Max IPAP: _____	Min EPAP: _____	PS Min & Max: _____		
☐	ResMed Adapt SV*	E0471	Min PS: _____	Max PS: _____	EPAP: _____		
☐	Respironics ASV*	E0471	PS Min & Max: _____	EPAP Min & Max: _____	Max Pressure: _____		
☐	BiPAP ST*	E0471	IPAP: _____	EPAP: _____	Resp Rate(BPM): _____		

* Heated humidifier (E0562) included with device unless otherwise specified: _____

✓ Select all medically necessary services

** "Supplies" are defined as a combination of the following equipment: masks (A7027, A7030, A7034, A7044), tubing (A7037, A4604), headgear (A7035), filters (A7038, A7039), water chambers (A7046), cushions/pillows (A7028, A7029, A7031, A7032, A7033), and chinstraps (A7036).

☐ **Provide an in-home setup of a PAP device and sleep therapy supplies**. Select the device type and settings above.**

☐ **Provide sleep therapy supplies**.**

☐ **Provide battery and required accessories:** Battery & DC cord for device (A4611, A4612, A4613)

☐ **Deployment Bag with battery and supplies**:** Default term = 12 months OR specify (Deployment term _____ months)

Medically necessary replacement supplies for deployment term						
HCPCS	**Equipment**	**3 mo**	**6 mo**	**9 mo**	**12 mo**	**Custom deployment term; Write-in # of units below**
A7027,A7030, A7034,A7044	Mask(s)	1	2	3	4	
A7037,A4604	Tubing	1	2	3	4	
A7038,A7039	Filter(s)	2	4	6	8	
A7046,A7035, A7036	Water tub(s), headgear, chinstrap(s)	1	1	2	2	

Please use this space to list any preferred manufacturer or equipment specific to this patient's needs:

Physician Signature: _____ Date: _____
Physician Name: _____ Physician NPI#: _____

FAX THIS ORDER TO (855) 773-0444 OR EMAIL THIS ORDER TO REFERRALS@CPAPMEDICAL.COM