

Provider Order Form for Sleep Apnea Equipment and Supplies

Patient Contact Information

Name: _____ **D.O.B.:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Email:** _____

Provider Contact Information

Name: _____ **Email:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Fax:** _____
National Provider Identification ("NPI") Number _____

Diagnosis Code (Check 1 or both)

- 327.23 Obstructive Sleep Apnea Functional Limits: OSA 327.27 Central Sleep Apnea Functional Limits: CSA

Please Indicate Type of PAP Equipment and Pressure (pressure is optional for Auto)

PAP Options: CPAP (E0601) Bi-Level (E0470) Bi-Level w/ RAD Back-up (E0471)
 Non-Auto: _____ IPAP___ EPAP___ _____ IPAP___ EPAP___
 Auto:

Supplies (check all that apply) **Humidification**

- Mask and other necessary supplies To include heated humidifier
 Check here to indicate other products _____ Other _____

Default order is for 99 months, unless indicated here Other _____

Other Comments:

Provider Signature: _____ Date: _____

(Must be one of the following: Doctor of Osteopathy, Medical Doctor, Psychiatrist, Physician's Assistant, Nurse Practitioners, Dentist, Orthodontist)

Please sign and return via fax to (877) 883-9709 or via email to info@easybreathe.com