

Patient Contact Information

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

Physician Contact Information

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

Diagnosis Code (Check 1 or both)

<input type="checkbox"/> Obstructive Sleep Apnea Functional Limits: OSA ICD-9: 327.23 ICD-10: G47.33	<input type="checkbox"/> Central Sleep Apnea Functional Limits: CSA ICD-9: 327.27 ICD-10: G47.37
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Supplies (check all that apply)

Mask and other necessary supplies (see list below)
 Check here to indicate other products _____

Humidification

To include heated humidifier
 Other _____

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

Detailed List of Supplies Necessary for the Proper Operation of PAP Equipment.

Full-Face Mask (A7030)	Headgear (A7035)	Oral Interface (A7044)
Full-Face Cushion (A7031)	Chinstrap (A7036)	Exhalation Port/Swivel (A7045)
Mask Cushion (A7032)	Tubing (A7037)	Humidifier Chamber (A7046)
Nasal Pillows (A7033)	Disposable Filters (A7038)	Non-Disposable Filters (A7039)
Nasal Mask (A7034)	Heated Humidifier Tubing w/Heating Element (A4604)	

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 fax@easybreathe.com