Provider Order Form for Sleep Apnea Supplies

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)

- [X] 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:	[X] CPAP (E0601)	[ ] Bi-Level (E0470)	[ ] Bi-Level w/ RAD Back-up (E0471)
[ ] Non-Auto:		IPAP___ EPAP___	IPAP___ EPAP___
[X] Auto:			

Supplies (check all that apply)

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

Humidification

- [X] 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 (A 7030)	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