BINSON'S Medical Equipment & Supplies Since 1953

FAX BACK TO:
Michigan Fax: 1-586-755-2322
Florida Fax: 1-407-691-3021
Indiana Fax: 1-574-365-6202

BECN 15279009638

CPAP - Detailed Written Order Before Delivery

Patient Name _____

Account Number _____ Patient DOB _____ Order Date _____

*****MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY**
Reason for Medical Necessity (other than diagnosis):

_____

DIAGNOSIS **Length of Need** _____ **(99 = Lifetime)**

☐ OSA

ADDITIONAL DIAGNOSIS (If AHI is below 15 /hr)

☐ Excessive Daytime Sleepiness
☐ Impaired Cognition
☐ Mood Disorder
☐ Hypertension
☐ Ischemic Heart Disease
☐ Stroke

CPAP EQUIPMENT

☐ CPAP w/ Humidifier (E0601/E0562) Settings _____ Cm H20 ERR _____
☐ Auto PAP (E0601/E0562) Settings _____ Cm H20
☐ Oxygen Bleed-In (E1390) _____ LPM

MASK OPTIONS *(Please check one mask option below)*

☐ Mask fit per patient's preference/tolerance 1 every 3 months
☐ Nasal Mask (A7034) 1 every 3 months
☐ Nasal Cushions (A7032) 5 every 5 months
☐ Pillows (A7033) 5 every 3 months

☐ Full Face Mask (A7030) 1 every 3 months
☐ Full Face Cushion (A7031) 1 per month

MEDICALLY NECESSARY ACCESSORIES *(check appropriate accessories below)*

☐ Tubing w/Heating (A4604) 1 every 3 months ***or***
☐ Tubing (A7037) 1 every 3 months

ADDITIONAL ACCESSORIES *(check appropriate accessories below)*

☐ Headgear (A7035) 1 every 6 months
☐ Chin Strap (A7036) 1 every 6 months
☐ Fine Filter (A7038) 6 every 3 months
☐ Water Chamber (A7046) 1 every 6 months
☐ Foam Filters (A7039) 1 every 6 months

SPECIAL INSTRUCTIONS

PRESCRIBING PHYSICIAN'S INFORMATION

Name and Credentials _____ NPI No. _____

Telephone No. _____ Fax No. _____

Signature _____ Date _____
(Stamped Signature Not Accepted)