1-888-BINSONS
Fax: 586-755-2322

BECN 15279009638

CPAP - Detailed Written Order Before Delivery

Patient Name ____

Account Number ______________________ Patient DOB ________________ Order Date __________________

☐ Face Sheet/Demographics/Chart Notes Attached/Sleep Study (Baseline & Titration) Faxed

- Chart notes must include the need for equipment being ordered. **Date of visit before order**: ________________

*****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
☐ 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)