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

reset form

BIPAP - Detailed Written Order Before Delivery

Patient Name _____

Account Number _____ Patient DOB _____ Order Date _____

- 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): _____

BIPAP – Covers Medical Necessity for New, Repair/Replacement of Irreparable/Obsolete Equipment

DIAGNOSIS *(Check applicable diagnosis below)* **Length of Need** _____ **(99 = Lifetime)**

☐ CSA ☐ COPD ☐ OSA ☐ COMPSA

NECESSITY FOR BIPAP DIAGNOSIS OTHER THAN OSA/CSA

☐ ABG patient's CO2>52mm

☐ OTHER: _____

BIPAP EQUIPMENT

☐ Auto BIPAP (E0470/E0562) IPAPMax _____ EPAP Min _____ PS _____
☐ BIPAP w/Humidifier (E0470/E0562) IPAP _____ EPAP _____
☐ BIPAP ST w/Humidifier (E0471/E0562) IPAP _____ EPAP _____ Backup Rate _____
☐ BIPAP Auto w/Humidifier (E0471) IPAP _____ Max EP EPAP Min/Max _____
Pressure Support Min/Max _____ Backup Rate _____

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

SPECIAL INSTRUCTIONS

PRESCRIBING PHYSICIAN'S INFORMATION

Name and Credentials _____ NPI No. _____

Telephone No. _____ Fax No. _____

Signature _____ Date _____
(Stamped Signature Not Accepted)