MyNewCPAP.com

FAX: (361) 214-1022

PHONE: 833-3MY-CPAP

ORDER FORM – Sleep Therapy Device

Date of Order: _____

Patient Name: _____ **DOB:** _____

Length of Need: Lifetime: 99 months Other_____(months)

ORDER (check all that apply):

- ☐ Sleep Therapy Device (see Sleep Therapy Device Options)
- ☐ Non-invasive Interface (see Interface Options)
- ☐ Heated Humidifier with Heated Tubing (HCPCS: E0562)
- ☐ Heated Humidifier with Non-heated Tubing (HCPCS: E0562)

Sleep Therapy Device Options (select one)

- ☐ Auto CPAP (HCPCS E0601): – 4cmH2O – 20cmH2O
- ☐ Auto CPAP (HCPCS E0601): - _____ cmH2O(specify range)
- ☐ Auto Bilevel (HCPCS E0470): MaxIPAP: 25cmH2O MinEPAP: 8cmH2O PS Min: 4cmH2O PS Max: 8cmH2O
- ☐ Auto Bilevel (HCPCS E0470): MaxIPAP: 25cmH2O MinEPAP: 4cmH2O PS Min: 4cmH2O PS Max: 8cmH2O
- ☐ Auto Bilevel (HCPCS E0470): MaxIPAP_____ cmH2O (specify pressure) MinEPAP_____ cmH2O (specify pressure)

  PS Min: _____cmH2O(specify pressure) PS Max:_____cmH2O(specify pressure)
- ☐ Fixed CPAP (HCPCS E0601): _____ cmH2O (specify pressure)
- ☐ Fixed Bilevel (HCPCS E0470): IPAP_____ cmH2O (specify pressure) EPAP_____ cmH2O (specify pressure)

Interface Options (select all that may apply)

- ☐ Nasal Pillow
- ☐ Nasal Mask
- ☐ Full Face Mask
- ☐ Patient Preference

Diagnosis: 1. _____ 2. _____ 3. _____

Ordering Physician (please print) _____ **NPI:** _____

Physician Signature: _____ **Date:** _____