PAP

MEDI-RENTS & SALES INC.

Physician Order/Prescription

Referred by: Name_____

Office_____

Phone #_____

DATE____/____/_____

800-540-7252

Fax completed form with Physician's Signature to 888-651-6709

Patient Information

Patient Name: Date of Birth: Gender M / F

Patient Phone #: Alternate Contact: Alternate Phone #:

Address: City: State: Zip Code:

Insurance & ID# Group # Social Security #:

Medicaid #: Secondary Insurance:

DISCHARGE DATE____/____/_____ DELIVERY DATE____/____/_____ DELIVER TO: (CIRCLE ONE) HOME OR REFERRAL

Prescribed Items

____CPAP Unit (E0601)_____cmH2O
____Auto CPAP Unit (E0601)_____cmH2O
____Bi-Level PAP Unit (E0470)IPAP_____cmH2O, EPAP_____cmH2O (Backup Rate_____)
____Auto Bi-Level Unit (E0470) with pressure support @ _____cmH2O
____ST / ASV / Auto SV PAP UNIT (E0471) _____
____Heated Humididier for use with CPAP machine (E0562) _____ Replacement Water Chamber (A7046)

____Nasal Mask (A7034)
____Nasel Mask Cushion (A7032)
____Nasel Mask Pillows (A7033)
____Full Face Mask (A7030)
____Full Face Mask Cushion(s) (A7031)
____Headgear (A7035)
____Chin Strap (A7036)
____Tubing (A7037)
____Heated Tubing (A4064)
____Filter(s)-disposable (A7038)
____Filter (s)-non-disposable (A7039)
____PreFab Oral Appliance (E0485)

Diagnosis Information

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) / Date last seen by Physician___/___/_____

DIAGNOSIS CODE/DESC (ICD): _____ DIAGNOSIS CODE/DESC (ICD): _____

DIAGNOSIS CODE/DESC (ICD): _____ DIAGNOSIS CODE/DESC (ICD): _____

Medical Justification _____ PLEASE SEND CLINICAL NOTES

Physician Information

Physician's Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

UPIN #: _____ NPI #: _____ License #: _____ Exp Date: ____/____/____ (MM / DD / YY)

Physician's Signature _____ **Date** ____/____/____ (MM / DD / YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Approved By ACHC