SLEEP CENTER OF KENTUCKIANA
7926 Preston Hwy. Suite 200
Louisville, KY 40219
Tel: (502) 964-2440
Fax: (866) 845-0491
www.KentuckySleep.com

ACCREDITED MEMBER CENTER

DWO Detailed Written Order

Patient Name: _____ DOB: _____

Social Security #: _____ Tel: _____

Address: _____

City: _____ St: _____ Zip: _____

Provider Name:
Sleep Center of Kentuckiana
7926 Preston Hwy. Suite 200
Louisville, KY 40219

Diagnosis: OSA

Length of Need for CPAP / Bi-Level Therapy 99 Month ☐ CPAP was Tried and Not tolerated

☐ With Heated Tubing Heated humidity (E0562) ☐ With ☐ Without

Ramp Time: ☐ None ☐ 15 Minutes ☐ 30 Minutes

NASAL MASK OR INTERFACE: or ☐ order best fit.

CPAP MACHINE NEED TO HAVE THE CAPABILITY TO RECORD AHI WITH HEATED HUMIDIFIER.

- ☐ *Replace supplies/accessories as needed*
- ☐ *E0562 Heated Humidifier*
- ☐ *A7034 Nasal Mask 1 per 3 months*
- ☐ *A7030 Full Face Mask Cushion 2 per month*
- ☐ *A7031 Full Face Mask 1 per 3 months*
- ☐ *A7032 Nasal Mask Cushion 2 per month*
- ☐ *A7033 Nasal Pillows for Cannula*
- ☐ *A7046 Humidifier Chamber 1 per 6 months*
- ☐ *A7027 Mask, Combo oral/nasal 1 per 3 months*
- ☐ *A7037 Tubing 1 per 3 months*
- ☐ *A7035 Headgear 1 per 6 months*
- ☐ *A7036 Chinstrap 1 per 6 months*
- ☐ *A7038 Disposable Filter 2 per months*
- ☐ *A7039 Non-Disposable Filter 1 per 6 months*

The items listed above are medically necessary. I certify the treatment of this patient. To my knowledge the foregoing information is true, accurate and complete. My signature indicates my approval. Per Medicare guidelines clinical conditions justifying need must and will be documented in physicians' records.

Referring Physician:

Address: 7926 Preston Hwy. Suite 200 City: Louisville State: KY Zip: 40219

Physician Signature _____ Date _____ Phone Number 502-964-2440