

LEXINGTON 277-2583 LOUISVILLE 502-625-2222 COVINGTON 513-221-0202 PRESTONSBURG 886-0072 SOMERSET 679-2454 WHITLEY CITY 376-2455



DETAILED WRITTEN ORDER - PAP/RAD/VENT

Order Date: _____

Length of Need (LON): 99 1-99 Months (99 = Lifetime)

PATIENT: _____ DOB _____

PHYSICIAN: _____ NPI _____

Phone _____ Fax _____

Dx / ICD-10: ① _____ ② _____ ③ _____

EQUIPMENT / ACCESSORIES / ORDER

Equipment HCPCS Code / Item Description / Ordered Settings

- E0601 CPAP device _____ cmH₂O
- E0601 APAP device Min _____ cmH₂O, Max _____ cmH₂O
- E0470 BiPAP device IPAP _____ cmH₂O, EPAP _____ cmH₂O
- E0470 BIPAP Auto device IPAP Max _____ cmH₂O, EPAP Min _____ cmH₂O, PS _____ cmH₂O
- E0471 BiPAP ST device IPAP _____ cmH₂O, EPAP _____ cmH₂O, Backup Rate _____ breaths per minute (bpm)
- E0471 BIPAP ASV device Max Press _____, EPAP Min _____ Max _____, PS Min _____ Max _____, Backup Rate _____ bpm
- E0465 Home Vent, Invasive AVAPS-AE; Max Press _____ cmH₂O, EPAP Min _____ Max _____, PS Min _____ Max _____, Backup Rate _____ bpm or Auto, Ti _____ seconds, Safety Vt _____ ml
- E0466 Home Vent, Non-Invasive

Hours/Duration of Use: Continuous During Sleep Other

Accessories HCPCS Code / Item Description / (Maximum Qty Allowed; Quantity Ordered)

- E0561 Non-Heated Humidifier
- E0562 Heated Humidifier
- A4483 Heat Moisture Exchanger
- A7046 Repl Water Chamber (1/6 mth; 2/yr)
- A7037 Tubing (1/3 mth; 4/yr)
- A4604 Tubing w/Heat Element (1/3 mth; 4/yr)
- A7036 Chinstrap (1/6 mth; 2/yr)
- A7038 Filter, Disposable (2/mth; 24/yr)
- A7039 Filter, Reusable (1/6 mth; 2/yr)
- A7035 Headgear (1/6 mth; 2/yr)
- A7027 Combo Mask (1/3 mth; 4/yr)
- A7028 Repl Oral Cushion (2/mth; 24/yr)
- A7029 Repl Nasal Pillows (2/mth; 24/yr)
- A7030 Full Face Mask (1/3 mth; 4/yr)
- A7031 Repl Full Face Cushion (1/mth; 12/yr)
- A7034 Nasal Interface (1/3 mth; 4/yr)
- A7032 Repl Nasal Cushion (2/mth; 24/yr)
- A7033 Repl Nasal Pillows (2/mth; 24/yr)
- A7044 Oral Interface (1/3 mth; 4/yr)
- Other _____
- Other _____

ORDERING PROVIDER'S SIGNATURE / DATE

X _____
Ordering Provider's Original Signature (Stamped Signatures Not Accepted)

X _____
Date