



MERIT Sleep Technologies, Inc.

Phone: (630) 652-7900

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CPAP & BI-LEVEL PHYSICIAN ORDER FORM

PATIENT
Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (Home) _____ (Cell) _____ (Work) _____
Email Address: _____
Please provide a copy of the following required patient information:
• Diagnostic & CPAP Titration Interpretations (only if sleep study not performed at MERIT)
• Insurance Card (copy of front and back)

TYPE OF THERAPY
Diagnosis: _____
CPAP/Bi-Level Therapy (Check all that apply): Length of Need: _____ [] Lifetime
[] CPAP Therapy (E0601) Pressure Setting: _____ CmH2O
[] Auto-Pap Therapy (E0601) Pressure Range: _____ / _____
Min Max
[] Bi-Level Therapy (E0470) Pressure Setting: _____ / _____
IPAP EPAP
[] Auto Bi-Level Therapy (E0470) Pressure Range: _____ / _____
Min EPAP Max IPAP Min PS Max PS
[] Bi-Level ST Therapy (E0471) Pressure Range: _____ / _____
IPAP EPAP Backup Rate
[] Bi-Level Auto SV/Adapt SV (E0471) Pressure Range: _____ / _____
Min EPAP Max IPAP Min PS Max PS
Max Pressure Backup Rate

ACCESSORIES
Accessories (Required): Length of Need: _____ [] Lifetime
[] Heated Humidity (E0562) [] Filter Disposable (A7038) [] Chin Strap (A7036)
[] Nasal Interface Mask (A7034) [] Filter Non Disposable (A7039) [] Full Face Cushion (A7031)
[] Headgear (A7035) [] Interface Full Face Mask (A7030) [] Replacement Nasal Pillows (A7033)
[] Water Chamber (A7046) [] Oral/Nasal Interface Pillows (A7027) [] Heated Tubing (A4604)
[] Tubing (A7037) [] Nasal Cushion (A7032)

Ordering Physician Name / NPI #

Signature

Date

For questions, please call 630-652-7900 and ask for the Respiratory DME Supervisor