CAPE MEDICAL SUPPLY

INNOVATING PATIENT CARE

PAP ORDER SHEET

Prescription and Medical Necessity

FAX: 508-888-6087

Date of Order: ______________

Patient Name: ______________________________ DOB: ________________ Gender ☐ M ☐ F

Mailing Address: ____

Street Address: ____

Phone #: ____________________ Email: ______________________________

Primary Insurance: ______________________________ Policy #: ____________________

Secondary Insurance: ______________________________ Policy #: ____________________

Order Type:	☐ New PAP Setup	☐ Auto Titration	☐ Pressure Change	☐ Replacement Machine	☐ Supplies

For New PAP Setup Please Attach:	☐ Patient Demographic Sheet	☐ - Diagnostic Sleep Study - Titration Sleep Study	☐ Copy of Face to Face (F2F) evaluation performed prior to Sleep Study. **Date of F2F:**____________

Diagnosis	**CPAP (E0601)**	**BIPAP (E0470)**	**BiPAP ST/ ASV (E0471)**	**Other PAP DX required if AHI within 5-14**
	☐ OSA (G4733)	☐ OSA (G4733)	☐ Central Sleep Apnea (G4731)	☐ Hypertension (I10)
		☐ COPD (J449)	☐ Complex Sleep Apnea (G4731)	☐ Excessive Daytime Sleepiness (G4710)
		☐ Hypoventilation Syndrome (E662)	☐ Hypoventilation Syndrome (E662)	☐ Insomnia (G4700)
				☐ Ischemic Heart Disease (I259)
X	**Therapeutic Objective:** To Treat OSA and Nightly Use			☐ Mood Disorder (F39)

Please Choose Mode and Associated Settings:

☐ **CPAP** (ALL) **Settings**			☐ **BIPAP AVAPS** (Respironics) **Settings**			☐ **BiPAP ASV Adv.** (Respironics) **Settings**		
Pressure		cm H20	Tidal Volume		ML	EPAP min		cm H2O
EPR or C-Flex		cm H2O	IPAP max		cm H2O	EPAP max		cm H2O
Auto Titration (5-20 cm H20)	☐		IPAP min		cm H2O	PS min		cm H2O
☐ **BIPAP Auto** (Respironics) **Settings**			EPAP		cm H2O	PS max		cm H2O
Max IPAP		cm H20	RR		BPM	Max Pressure		cm H2O
Min EPAP		cm H20	Rise Time		or default	Back up rate		BPM
PS Min		cm H20	☐ **VPAP ST-A iVAPS** (Resmed) **Settings**			☐ **VPAP Adapt SV** (Resmed) **Settings**		
PS Max		cm H20	EPAP		cm H2O	EEP		cm H2O
☐ **VPAP Auto** (Resmed) **Settings**			Target Va		Liters	PS min		cm H2O
Max IPAP		cm H20	Target Va		BPM	PS max		cm H2O
Min EPAP		cm H20	Min PS		cm H2O	Back Up rate	AUTO	
PS		cm H20	Max PS		cm H2O			
			Ti Max		seconds			
X **Length of Need**	**99 Years**		Ti Min		seconds			

Supplemental Oxygen	☐ Inline w/PAP device	☐ (LPM) Liters Per Minute

Supplies										
	X	Humidifier - Heated (E0562)	X	Oral/Nasal Mask (A7027)	X	Oral/Nasal Cushion (A7028)	X	Oral/Nasal Pillows (A7029)	X	Full Face Mask (A7030)
	X	Full Face Cushion (A7031)	X	Nasal Cushion (A7032)	X	Nasal Pillow (A7033)	X	Nasal Mask (A7034)	X	Headgear (A7035)
	X	Chin Strap (A7036)	X	Tubing (A7037)	X	Tubing- Heated (A4604)	X	Filter- Disp. (A7038)	X	Filter- Reusable (A7039)
	X	Oral Mask (A7044)	X	Humidifier Chamber (A7046)	X	Length of Need Lifetime/99 years				

Physician's signature certifies that the above represents physician's judgment of the patient's medical need for the equipment and supplies.

Physician Name: ______________________________ **Phone #** ____________________

Physician Signature: ______________________**Date:**__________ **NPI #** ____________________