SLEEP THERAPY PRESCRIPTION

sleep metrics
Sleep well. Be well.

COMPLETE AND FAX ORDER TO: 1-888-503-DOZE (3693)

Please Include:
- A front/back copy of patient's insurance
- Sleep questionnaire results if available
- Chart notes relating to OSA concerns

1. PATIENT INFO

Name: _____ DOB: _____ Sex: M / F

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____

****A COPY (FRONT AND BACK) OF INSURANCE CARD IS REQUIRED WITH THIS FORM****

2. PRESCRIPTION

Medical Necessity
(Check all that apply)

- ☐ Obstructive Sleep Apnea (G47.33)
- ☐ Central Sleep Apnea (G47.31)
- ☐ Excessive Daytime Sleepiness (G47.10)
- ☐ Periodic Limb Movement (G47.61) _____
- ☐ Chronic Ischemic Heart Disease (I25) _____
- ☐ Essential Hypertension (I10) _____
- ☐ COPD (J44.9)
- ☐ Snoring (R06.83)
- ☐ Cheyne-Stokes (R06.3)

Start of Care Date: _____

Length of Need: ☐ 99/Lifetime

☐ Other: _____

CPAP/BI-Level Equipment

- ☐ E0601 CPAP Unit _____cmH2O
- ☐ E0601 Auto CPAP _____-_____cmH2O
- ☐ E0470 Bi-level Unit _____/_____cmH2O
- ☐ E0470 Auto Bi-level Unit _____-_____cmH2O
- ☐ A9279 Compliance Monitoring Modem (wireless)
- ☐ 94660 RT Evaluation and PAP Setup
- ☐ Other: _____

Humidifier

- ☐ E0562 Heated CPAP Humidifier

CPAP/Bi-Level Supplies

- ☐ A7027-A7029 Hybrid Mask/Cushions (Quarterly)
- ☐ A7030 Full Face Mask (Quarterly)
- ☐ A7031 Face Mask Flap (Monthly)
- ☐ A7032 Seals/Cushions/Flaps (Bi-Weekly)
- ☐ A7033 Nasal Pillows (Bi-Weekly)
- ☐ A7034 Nasal Application Device (Quarterly)
- ☐ A7035 Headgear (Semi-Annually)
- ☐ A7036 Chin Strap (Semi-Annually)
- ☐ A4604 Tubing - Heated (Quarterly)
- ☐ A7037 Tubing (Quarterly)
- ☐ A7038 Filters - Disposable (Bi-Weekly)
- ☐ A7039 Filters - Non-Disposable (Semi-Annually)
- ☐ A7044 Oral Interface (Quarterly)
- ☐ A7046 Replacement Water Chamber

3. PROVIDER INFORMATION

Letter of Medical Necessity:
The above referenced patient has an absolute Medical Necessity for the item(s) listed above. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the standards of medical practice for this patient's condition.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI: _____

_____ _____

PROVIDER SIGNATURE **Date**

4. SEND WITH INSURANCE AND CHART NOTES TO 888-503-DOZE(3693)