CPAP & BIPAP Standard Written Order

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Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to coverage criteria sheet for all required documentation.

CPAP & BIPAP:

Diagnosis: (Choose One) ☐ Obstructive Sleep Apnea (G47.33) ☐ Central Sleep Apnea (G47.31)

☐ Sleep Hypoventilation (G47.34) ☐ Other: _____

Length of Need (# of months) _____ 1-99 (99=lifetime) Date of last visit: _____

☐ CPAP (E0601) with heated humidifier (E0562)

Pressure _____ (4-20 cmH2O), Expiratory Relief ____ (1-3)

Ramp time _____ minutes (Auto or 0-45 minutes)

☐ CPAP-AUTO (E0601) with heated humidifier (E0562)

Min Pressure _____ (4-20 cmH2O) Max pressure _____ (4-20 cmH2O)

Expiratory Relief ____ (1-3), Ramp time ____ (Auto or 0-45 minutes)

☐ BiLevel S (E0470) with heated humidifier (E0562)

IPAP _____ (4-25 cmH2O), EPAP _____ (3-25 cmH2O),

Easy Breath _____ (On or Off)

☐ BiLevel-AUTO(E0470) with heated humidifier (E0562)

☐ Auto Mode

Max IPAP ____ (4-25 cmH2O), Min EPAP ____ (4-25 cmH2O), Pressure Support ____ (0-10 cmH2O), Ramp time ____ minutes (Auto or 0-45 minutes)

☐ Spontaneous Mode

Max IPAP ____ (4-25 cmH2O), Min EPAP ____ (4-25 cmH2O), Pressure Support ____ (0-10 cmH2O), Ramp time ____ minutes (Auto or 0-45 minutes)

☐ BiLevel S/T (E0471) with heated humidifier (E0562)

IPAP ____ (4-25 cmH2O), EPAP ____ (4-25 cmH2O), RR ____, Rise Time _____ (100-900 ms, Rise of 1 = 100ms, 2 = 200 ms, etc.)

☐ BiLevel (ASV) (E0471) with heated humidifier (E0562)

☐ ASV Mode ☐ ASV Auto Mode

Min EPAP ____ (4-15 cmH2O), Max EPAP ____ (4-15 cmH2O) Min Pressure Support (PS) ____ (0-6 cmH2O), Max Pressure Support (PS) ____ (5-20 cmH2O), Has automatic Dynamic back up rate built-in, automatic easy breath waveform.

☐ BiLevel Aircurve S/T-A (E0471) with heated humidifier (E0562)

☐ Timed Mode

IPAP _____ (4-24 cmH2O), EPAP ____ (4-25 cmH2O) RR ____ Ti inspiratory time ____ (0.1-4.0 sec), Rise Time ____ (100-900 ms, Rise of 1 = 100 ms, 2 = 200 ms, etc.)

☐ S/T Mode

IPAP _____ (4-24 cmH2O), EPAP ____ (4-25 cmH2O) RR ____ Ti inspiratory time ____ (0.1-4.0 sec), Rise Time ____ (100-900 ms, Rise of 1 = 100 ms, 2 = 200 ms, etc.)

☐ iVAPS Mode

Height ____ in. (44-100 inches) Target RR ____, Target tidal volume ____, EPAP ____, Pressure Support Min ____ (0-20 cmsH2O), Pressure Support Max ____ (0-27 cmH2O)

Supplemental Oxygen

☐ Continuous Oxygen at _____ ☐ Nocturnal Oxygen at _____ ☐ Bleed into CPAP/BiPAP when sleeping

Supplies

☐ Full face mask (A7030) w/headgear (A7035) every 3 months, with 1FF cushion (A7031) every month

☐ Nasal mask (A7034) w/headgear (A7035) every 3 months, with 2 nasal cushions (A7032) or 2 nasal pillows (A7033) every month

☐ Tubing – Heated (A4604) or Non-Heated (A7037) 1 every month

☐ Water Chamber (A7046) – 1 every 6 months

☐ Chin Strap (A7036) – 1 every 6 months

☐ Filter, Disposable (A7038) – 2/month

☐ Filter, Non-Disposable (A7039) – 1 every 6 months

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____