CPAP & BIPAP Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

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: _____

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: _____