30150 Telegraph Rd., Suite 185, Bingham Farms, MI 48025
P: 877-363-7133 F: 248-307-9557 info@thedmesource.com

PAP PRESCRIPTION ORDER FORM

Patient Information:

Last Name: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ DOB: _____

Phone: _____ Email: _____

Insurance: _____

ID #: _____ Group #: _____

Length of Need (99=Lifetime): _____

Diagnosis/ICD-10: ❑ G47.33 (OSA) ❑ Other: _____

Order Information:

❑ CPAP:_____cm H_2O ❑ BPAP:_____/_____cm H_2O ❑ APAP:_____-_____cm H_2O

❑ Supplies (mask, headgear, tube & filters) ❑ Heated Humidifier ❑ Heated Tube ❑ Chin Strap

❑ Other: _____

All PAP device accessories may be replaced at the following frequencies unless otherwise noted by physician: Heated Tube (1 per 3 months), Full Face Mask (1 per 3 months), Full Face Cushion (1 per month), Nasal Mask Cushion (2 per month), Nasal Pillows (2 per month), Nasal/Pillow Mask (1 per 3 months), Headgear (1 per 6 months), Chinstrap (1 per 6 months), Tubing (1 per 3 months), Disposable Filter (2 per month), Non-disposable Filter (1 per 6 months), Humidifier Water Chamber (1 per 6 months).

I certify that the above prescribed equipment is medically indicated and supports standards of medical practice for this diagnosis.

Ordering Doctor: _____ **NPI:** _____

Signature: _____ **Date:** _____

Hospital/Facility Name: _____ **Phone:** _____

Please fax completed form to 248-307-9557