CRESTHAVEN
MEDICAL SUPPLY

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SLEEP APNEA/PAP PRESCRIPTION ORDER FORM

Patient Information **(BOLD Required):**
Last Name: _____ **First Name**: _____
Address: _____ City: _____
State: _____ **Zip Code**: _____ **DOB**: _____
Phone: _____ Email (Optional): _____
Insurance (Medicare/Medicaid/BWC/OTHER):_____
ID #: _____ Group #: _____
Length of Need (Daily/Weekly/Monthly/Lifetime): _____

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

Order Information:

❑ CPAP (E0601) ❑ APAP (E0601) ❑ BPAP (E0470) ❑ Auto BPAP (E0470)
Pressure settings (cm H 2O): _____
❑ Heated Humidifier (E0562)
❑ A4604 Heated Tubing (4/year) ❑ A7035 Headgear (2/year)
❑ A7030 Full Face Mask (4/year) ❑ A7036 Chin Strap (2/year)
❑ A7031 Full Face Cushion (1/month) ❑ A7037 Tubing (4/year)
❑ A7032 Nasal Cushion (2/month) ❑ A7038 Disposable Filter (2/month)
❑ A7033 Nasal Pillow (2/month) ❑ A7039 Non-Disposable Filter (2/year)
❑ A7034 Nasal/Pillow Mask (4/year) ❑ A7046 Humidifier Chamber (2/year)

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

Name of Requestor: _____ **Phone**: _____
Signature: _____ **NPI#**:_____ **Date:** _____
Hospital/Facility Name: _____

Please fax completed form to 614-600-1645