CPAP/BiPAP Order Form

Please include ALL sleep studies and applicable clinical visit notes.

Intermountain Health

Home Medical Equipment
Toll Free: 1-800-527-1118
Phone: 385-887-7366
Fax: 801-442-0709
24 hours a day / 7 days a week

PATIENT INFORMATION

Male ◯ Female ◯

Patient Name:_____ Gender: ◯ ◯ DOB: _____
(Last) (First) (Mi)

Address: _____
(Street) (City) (State) (Zip)

Phone #1:_____ Phone #2:_____ Height:_____ Weight:_____

Primary Ins./ID Number:_____ Secondary Ins./ID Number:_____

Referring Doctor Name:_____ Faxed By: _____

Date of Sleep Study*:_____ Location of Study: _____

Sleep Time:_____ AHI:_____/hr or RDI:_____/hr Low SpO_2:_____ Hypopneas:_____ Apneas:_____

DIAGNOSIS

☐ OSA 327.23
☐ Primary Central Apnea 327.21
☐ Hypoxia 799.02
☐ Other (Please Specify) _____

PRESCRIPTION (Select type and then fill in the settings applicable to your selection.)

Length of Need {99=Lifetime): _____ months

CPAP

◯ CPAP [E0601] machine capabilities: 4cmH2O to 20cmH2O. Set mode at ____ cm/H_2O E0601

◯ Auto Titrating CPAP —Settings:_____ to_____cm/H_2O E0601
AUTO PAP at _____ min _____ max

Bi-PAP

◯ BiPAP w/OUT Backup [E0470] (machine capabilities: 4–25 cmH2O / PS 0-10 cmH2O)
SONTANEOUS MODE: IPAP_____cmH2O / EPAP_____cmH2O
VAuo MODE: Min EPAP_____cmH2O / Max IPAP_____cmH2O / PS_____cmH2O

◯ BiPAP ASV WITH Backup [E0471] (Machine capabilities: EPAP 4–15 cmH2O / Min PS 0–6 cmH2O / Max PS 5–20 cmH2O)
ASV MODE: EPAP_____cmH2O / PS_____to_____cmH2O
ASV AUTO MODE: EPAP_____to_____cmH2O / PS_____to_____cmH2O

◯ BiPAP ST WITH Backup [E0471] (machine capabilities: IPAP 4–25 cmH2O / EPAP 3–25 cmH2O / RATE: 5–50 BPM)
Spont/Timed MODE: IPAP_____cmH2O / EPAP_____cmH2O / RATE:_____BPM

◯ BiPAP ST-A WITH Backup [E0471]
(machine capabilities IN ST MODE: IPAP 4–30 cmH2O / EPAP 3–25 cmH2O / RATE: 5–50 BPM / Ti: 0.1–4 seconds)
(machine capabilities in iVAPS MODE: EPAP 3–25 cmH2O / Min PS 0–20 cmH2O / Max PS 0–27 cmH2O / Height: 44"–100" / RATE: 8-30 BPM / Target Va 1 – 30 L/Minute)
Spnt/Timed MODE: IPAP_____cmH2O / EPAP_____cmH2O / Rate:_____BPM / Ti:_____seconds
iVAPS MODE: EPAP_____cmH2O / PS_____to_____cmH2O / Height:_____inches / RATE:_____BPM / Target Va:_____L/Minute

☐ Heated Humidifier
☐ Preferred Mask:_____
☐ Full Face Mask
☐ No Mask Preference; Please Fit

☐ Please supply the following CPAP supplies:

- A4604 TUBING WITH INTEGRATED HEATING ELEMENT; 1 EVERY 3 MONTHS
- A7027 COMBINATION ORAL/NASAL MASK; 1 EVERY 3 MONTHS
- A7028 ORAL CUSHION FOR COMBINATION ORAL/NASAL; 2 EVERY MONTH A7030 FULL FACE MASK; 1 EVERY 3 MONTHS
- A7031 FACE MASK INTERFACE, REPLACEMENT; 1 EVERY MONTH
- A7032 CUSHION FOR USE ON NASAL MASK INTERFACE; 2 EVERY MONTH
- A7033 PILLOW FOR USE ON NASAL CANNULA TYPE; 2 EVERY MONTH
- A7034 NASAL INTERFACE (MASK OR CANNULA TYPE); 1 EVERY 3 MONTHS
- A7035 HEADGEAR USED WITH PAP DEVICE; 1 EVERY 3 MONTHS
- A7036 CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE; 1 EVERY 6 MONTHS
- A7037 TUBING USED WITH POSITIVE AIRWAY PRESSURE; 1 EVERY 3 MONTHS
- A7038 FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY; 2 EVERY MONTH
- A7039 FILTER, NON-DISPOSABLE, USED WITH PAP; 1 EVERY 6 MONTHS
- A7046 WATER CHAMBER FOR HUMIDIFIER, USED WITH PAP; 1 EVERY 6 MONTHS

I certify the above prescription is medically necessary.

Physician Signature_____ **Date**_____ **NPI**_____

Revised 10-3-2024