Insurance Covered CPAP

CPAP Prescription

Phone 888-510-5100 • **Fax** 309-664-7931
Email orders@insurancecoveredcpap.com

Patient Name: ______________________ DOB: ______________

Address: ______________________ Parent/Guardian: ______________

Phone: ______________________ Email: ______________

Policy Holder Name: ______________________ Insurance Name: ______________

Policy ID #: ______________________ Policy Group #: ______________

Diagnosis

☐ G47.33 Obstructive Sleep Apnea ☐ G47.31 Central Sleep Apnea

Testing

☐ Unattended Sleep Study/Home Sleep Test (G47.33)

☐ Overnight Oximetry ☐ On CPAP/BiPAP ☐ On Ventilator ☐ On Oxygen ☐ On Room Air

Equipment Information

Device Type & Settings

☐ CPAP (E0601) ______________ cmH20

☐ Auto CPAP (E0601) 5-50 or Min Pressure ______________ Max ______________

☐ Auto BiPAP (E0470) Auto Settings 5-25 ________ Min EPAP ________ Max IPAP ________ PS ________

Humidification

☐ Heated (E0652)

Tubing

☐ Heated Tubing (A4604): 1 per 3 mo. ☐ Regular Tubing (A7037): 1 per 3 mo.

Mask

☐ Nasal Mask (A7034); 1 per 3 mo.; Brand Name ______________

☐ Full Face Mask (A7030); 1 per 3 mo.; Brand Name ______________

☐ Mask to Fit ______________

Related Supplies

☐ Chin Strap (A7036); 1 per 6 mo. ☐ Water Chamber (A7046); 1 per 6 mo. ☐ Headgear (A7035); 1 per 6 mo.

☐ Disposable Filters (A7038); 2 per 1 mo. ☐ Non Disposable Filters (A7039); 1 per 6 mo.

I certify the above prescribed equipment is medically indicated and supports accepted standards of medical practice for this patient's condition.

Clinic Name: ______________________ Phone: ______________

Address: ______________________ Fax: ______________

Physician Name: ______________________ NPI: ______________

Physician Signature: ______________________ Date: ______________

PLEASE EMAIL OR FAX THIS PRESCRIPTION WITH PATIENT INSURANCE / DEMOGRAPHICS