



Toll Free Fax: 800-249-1513

Toll Free Phone: 888-345-1780

PATIENT INFORMATION:

Patient Name: DOB: SS #: Sex: Phone:
HGT: WGT: Alt Contact: Relationship: Phone:
Street: City: State: ZIP:
1st Insurance: Policy #: Group #: Phone:
2nd Insurance: Policy #: Group #: Phone:

PRESCRIBER INFORMATION:

Prescriber's Name: NPI #: Street:
City: State: ZIP: Fax: Phone:

DIAGNOSIS: Length of Need: 99

HOME OXYGEN Cont (E1390&E0431) Nocturnal (E1390)@ LPM O2 SAT: (must be <=89%)
x A9901 Conserving Test (If patient qualifies for conserver, please dispense) x E1353 Conserving Oxygen Regulator

CPAP(E0601) BIPAP(E0470) AUTO TITRATE THE CPAP/BIAP Pressure Range: 5-20cmH2O
x A7034 Nasal Interface x A7035 Headgear x A7039 Non-disposable Filter x A9901 Setup & Delivery x A7030 Full Face Mask
x A7036 Chinstrap x A7044 Oral Interface x A7033 Nasal Pillows x A7037 Tubing x A7038 Disposable Filter
x A9279 Monitoring Feature x E0562 Heated Humidifier x A7045 Exhalation Port

OVERNIGHT OXIMETRY for nocturnal hypoxemia due to COPD or other lung disease.
On Room Air On CPAP On BiPAP On Oxygen
IF OVERNIGHT OXIMETRY IS ABNORMAL FOLLOW CLINICAL RECOMMENDATIONS AND BEGIN TREATMENT VIA OXYGEN OR MOVE FORWARD WITH A SLEEP STUDY.

HOME NEBULIZER THERAPY(E0570 or E0575) x A7005 Non-disposable Set x A7013 Filter x A9901 Setup & Delivery
Medication: or generic equivalent Frequency: Refills:

MOBILITY ASSESSMENT Aeroflow will assess the patient for a mobility assistive device.

UNATTENDED SLEEP STUDY - 95806, G0399, G0400
Home Sleep Test/Type 3 Portable—for suspicion of SDB (Sleep Disorder Breathing) – Diagnosis: 327.23
On Room Air On CPAP On Oxygen
IF SLEEP STUDY IS ABNORMAL - FOLLOW SLEEP MD RECOMMENDATIONS AND BEGIN TREATMENT (IF WARRANTED) VIA CPAP/BIPAP/OXYGEN
IF SLEEP STUDY IS ABNORMAL – REFER PATIENT TO INTERPRETING PHYSICIAN TO MANAGE ILLNESS, AND PRESCRIBE NECESSARY TREATMENT

ATTENDED SLEEP STUDY / POLYSOMNOGRAPHY (PSG) - 95810, 95811, 95805

Comments:

ONLY APPLIES TO MEDICARE UNATTENDED SLEEP STUDY ORDERS: I, the undersigned, understand that by completing the form and signing below that I am ordering a Home Sleep Test for patient listed above. I also understand that Medicare guidelines require a face-to-face evaluation for Obstructive Sleep Apnea to be documented in the patient's chart prior to a home sleep test and that this test will be done by an IDTF, Instant Diagnostic Systems.

Physician's Signature: Date:

FAX ORDERS TOLL FREE TO: 1-800-249-1513