



Call Us Now
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 Url: https://melodyhomehealth.com

Private Insurance: _____
 Medicaid Medicare Self Pay
 Policy # _____

CPAP / BIPAP & TRACH ORDER FORM

Patient Name: _____ **Date of Birth:** _____ **RX Date:** _____

Diagnosis: COPD (J44.9) Central Sleep Apnea (G47.31) Complex Sleep Apnea (G47.37)
 OSA (G47.33) Hypoventilation Syndrome (G47.35)

Neuromuscular Disease Dx of _____ Other _____

Length of Need: _____ (If lifetime, use 99)

PAP Equipment

AHI: _____ RDI: _____

CPAP _____ CmH2O _____ **BIPAP** _____ IPAP _____ EPAP _____

BIPAP ST _____ IPAP _____ EPAP _____ Back-up Rate _____

PAP SUPPLIES

- | | |
|---|---|
| <input type="checkbox"/> A4604 Tubing, Heated(1 per 3 months) | <input type="checkbox"/> A7034 Nasal Mask (1 per 3 months) |
| <input type="checkbox"/> A7027 Oral/Nasal Mask (1 per 3 months) | <input type="checkbox"/> A7035 Headgear Device (1 per 6 months) |
| <input type="checkbox"/> A7028 Oral Cushion (2 per month) | <input type="checkbox"/> A7036 Chinstrap Device (1 per 6 months) |
| <input type="checkbox"/> A7029 Nasal Pillows (2 per month) | <input type="checkbox"/> A7037 Tubing, CPAP (1 per 3 months) A7038 |
| <input type="checkbox"/> A7030 Full Face Mask (1 per 3 months) | <input type="checkbox"/> Filter, Disposable (2per month) A7039 Filter,
Non-Disposable (1 per 6mos) |
| <input type="checkbox"/> A7031 Face Mask Interface (1 per month) | <input type="checkbox"/> A7046 Humidifier Chamber |
| <input type="checkbox"/> A7032 Nasal Cushion Replacement(2 per month) | <input type="checkbox"/> E0562 Heated Humidifier |
| <input type="checkbox"/> A7033 Nasal Pillow Replacement (2 per month) | |

TRACHEOSTOMY SUPPLIES:

Diagnosis: Z93.0 – Tracheostomy Status Z43.0 Attention to Tracheostomy Other _____

D02.0 – CA In Situ Larynx D02.1 – CA In Situ Trachea Prognosis_____

Suction Machine (E0600) Suction Tubing (A7002)

Suction Cannister A7000 Disposable qty_____ A7001 Non-disposable qty_____

Suction Catheter (A4624) – French: _____ (Trach) Suction Catheter Kit (A4628) – French: _____ (Oral Suction)

Normal Saline A4216 10 ml A4217 500 ml

Inner Cannula (Shiley) (A4622) Larynectomy Tracheostomy Size: _____

Disposable Cuffless Cuffed Fenestrated

Please provide a copy of sleep study and face-to-face chart notes prior to sleep study with the order

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

Physician's Printed Name: _____

NPI: _____

Fax: _____

Physician's Signature: _____

Signature Date: _____

Medicare requires the Signature and Signature Date be completed by a PECOS enrolled MD, DO, PA, NP, or CNS

THANK YOU FOR YOUR REFERRAL ORDER!