



Written Order Prior to Delivery (WOPD) PAP Device

Prism Health Care Services, Inc. 1337 Basswood Road Schaumburg, IL 60173-4536 Phone: 847-310-4730 *3 Fax: 872-469-1673

Order Date: _____

Patient Name: _____

Home Phone: _____

Date of Birth: _____

Cell Phone: _____

- Diagnosis: [] G47.33 Obstructive Sleep Apnea [] G47.31 Central Sleep Apnea [] G47.39 Other sleep apnea [] G47.37 Central sleep apnea in conditions classified elsewhere [] Other: _____

PAP Device - Select one and indicate settings.

Cpap (E0601) [] _____ cwp EPR / CFlex _____

Auto Cpap (E0601) [] _____ to _____ cwp

If a Bilevel is being ordered, documentation provided must show evidence of a therapeutic trial on cpap has been tried and proven ineffective.

Bilevel (E0470) [] IPAP _____ cwp EPAP _____ cwp

Bilevel Auto (E0470) [] IPAP max. _____ cwp EPAP min. _____ cwp Pressure Support (PS) _____

Bilevel ST (E0471) [] IPAP _____ cwp EPAP _____ cwp Back up Rate of _____

Resmed VPAP Adapt (E0471) [] EEP _____ CWP _____ PS min _____ PS max _____

Resmed VPAP Adapt Auto (E0471) [] EPAP min _____ max _____ PS min _____ PS max _____

Respironics Bipap Auto SV (E0471) [] IPAP (range 4-25) _____ EPAP (range 4-25) _____ PS min _____ PS max _____ Backup Rate Set _____ or Auto _____

Resmed STA iVAPS (E0471) [] Tidal Volume _____ PS max _____ PS min _____ EPAP _____ Backup Rate _____ Ti min _____ Ti max _____ Trigger _____ Cycle _____ Rise _____ Patient's Height _____

Humidifier - Select the humidifier chamber if humidification is ordered.

[] Heated (E0562)

[] Cool (E0561)

[] 2/year - Humidifier Chamber (A7046) Dispense 1 Chamber every 6 months

Accessories - Tubing (select one) & Filters (select all that apply).

[] 4/year -Heated (A4604) Dispense 1 every 3 months

[] 12/year - Disposable - (A7038) Dispense 2 per month

[] 2/year - Chin Strap (A7036) Dispense 1 every 6 months

[] 2/year - Standard (A7037) Dispense 1 every 6 months

[] 2/year - Non-Disposable (A7039) Dispense 1 every 6 months

Mask Options - Select Full, Nasal, Nasal Pillows OR Customer Choice for Mask

[] Allow Customer to Select Mask of Choice (a detailed written order will be sent to you after setup is completed.)

Full Face Mask

(select all if a full face mask is ordered) [] 4/year -Mask (A7030) Dispense 1 every 3 months

[] 12/year - Repl Cushion (A7031) Dispense 1 per month

[] 2/year - Headgear (A7035) Dispense 1 every 6 months

Nasal Mask

(select all if a nasal face mask is ordered) [] 4/year - Mask (A7034) Dispense 1 every 3 months

[] 24/year - Repl Cushion (A7032) Dispense 2 per month

[] 2/year - Headgear (A7035) Dispense 1 every 6 months

Nasal Pillows

(select all if a nasal pillow mask is ordered) [] 4/year - Mask (A7034) Dispense 1 every 3 months

[] 24/year - Repl Pillows-Pair (A7033) Dispense 2 pair per month

[] 2/year - Headgear (A7035) Dispense 1 every 6 months

If the patient is currently receiving oxygen therapy, please complete: Nocturnal Oxygen Bleed In _____ LPM

Physician Name: _____

NPI: _____

Physician Signature: _____

Date: _____

Physician Phone: _____

Fax: _____