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: _____

Duration: ☐ Lifetime (99) Other _____

PAP DEVICE (select one and indicate settings)

Cpap (E0601) ☐ _____ **cwp** ☐ **EPR / CFlex** _____

Auto Cpap (E0601) ☐ _____**to**_____ **cwp**

If a Bilevel is being ordered, has the cpap been tried and proven ineffective based on a therapeutic trial? Yes No (please circle)

Bilevel (E0470) ☐ **IPAP** _____ **cwp, EPAP** _____ **cwp**

Bilevel Auto (E0470) ☐ **IPAP max.** _____ **cwp, EPAP min.** _____ **cwp. PS**_____

Bilevel ST (E0471) ☐ **IPAP** _____ **cwp, EPAP** _____ **cwp, Breathing Rate of** _____ **/minute.**

Resmed VPAP Adapt (E0471) ☐ **EEP**_____**CWP PS min** _____ **PS max**_____

Resmed VPAP Adapt Auto (E0471) ☐ **EEP 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** _____

HUMIDIFIER (select one)
☐ **Heated (E0562)**
☐ **Cool (E0561)**

TUBING (select one)
☐ **Heated (A4604) 1/3 months**
☐ **Standard (A7037) 1/6 months**

FILTERS (select all that are required)
☐ **Disposable - (A7038) 2/month**
☐ **Non-Disposable (A7039) 1 /6 months**

Mask Options - Select Full, Nasal, or Pillows (Order must only be for one mask type. Submit an additional order for other mask types.)

Full Face Mask (select all if the full face mask is ordered)
☐ **Mask (A7030) 1/3 months** ☐ **Repl Cushion (A7031) 1/month** ☐ **Headgear (A7035) 1/6 months**

Nasal Mask (select all if a nasal face mask is ordered)
☐ **Mask (A7034) 1/3 months** ☐ **Repl Cushion (A7032) 1/month** ☐ **Headgear (A7035) 1/6 months**

Nasal Pillows (select all if a nasal pillows mask are ordered)
☐ **Mask (A7034) 1/3 months** ☐ **Repl Pillows (A7033) 1 set/month** ☐ **Headgear (A7035) 1/6 months**

Other Accessories
☐ **Repl Water Chamber for Humidifier (A7046) 1/6months**
☐ **Chin Strap (A7036) 1/6months**
☐ **Compliance Monitoring (A9279)**

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

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.