PAP Device

Standard Written Order (SWO)

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, 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 the humidifier chamber if humidfication is ordered.

- ☐ Heated (E0562)
- ☐ Cool (E0561)
- ☐ Repl Water Chamber for Humidifier (A7046) Dispense 1 every 6 months

Accessories

TUBING (select one)
- ☐ Heated (A4604) Dispense 1 every 3 months
- ☐ Standard (A7037) Dispense 1 every 3 months

FILTERS (select all that are required)
- ☐ Disposable - (A7038) Dispense 2 per month
- ☐ Non-Disposable (A7039) Dispense 1 every 6 months
- ☐ Chin Strap (A7036) Dispense 1 every 6 months

Mask Options - Select Full, Nasal, Nasal Pillows OR Customers Mask of Choice

Mask of Choice (allows mask of choice and supplies to be dispensed)

☐ **1. Full Face (A7030) 1/3 months, Full Face Cushions (A7031) 1/month and Headgear (A7035) 1/6 months, OR,**
2. Nasal Mask (A7034) 1/3 months, Nasal Cushions (A7032) 2/month and Headgear (A7035) 1/6 months, OR,
3. Nasal Mask (A7034) 1/3 months, Nasal Pillows (A7033) 2/month and Headgear (A7035) 1/6 months

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

Nasal Mask (select all if a nasal face mask is ordered)
- ☐ Mask (A7034) Dispense 1 every 3 months
- ☐ Repl Cushion (A7032) Dispense 2 per month
- ☐ Headgear (A7035) Dispense 1 every 6 months

Nasal Pillows (select all if a nasal pillow mask is ordered)
- ☐ Mask (A7034) 1/3 months Dispense 1 every 3 months
- ☐ Repl Pillows-Pair (A7033) Dispense 2 pair per month
- ☐ 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:** _____

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.