Prescription for Therapy

Patient	
DOB	
Home Phone	
Cell Phone	
Address	

Order Date	
Diagnostic Sleep Test	
Test Date	
AHI Total	
Sleep Time (min)	
O2 Nadir %	
Diagnosis	

Statement of Medical Necessity:

The above patient has undergone diagnostic evaluation. This evaluation has confirmed a positive diagnosis of sleep apnea. Positive airway pressure therapy is medically necessary and provides effective treatment of this disorder.

Equipment		Settings		Length of Need – Lifetime (99 Months)
X	E0601 Auto	4-20cm of H2O pressure	X	Heated Humidifier

Supplies		Replacement Instructions	Supplies		Replacement Instructions
X	Please dispense Mask that fits the best	1 per 6 mo	X	Headgear	1 per 6 mo
X	Replacement Interface	1 per 3 mo	X	Chinstrap	1 per 6 mo
X	Water Chamber Humidifier	1 per 6 mo	X	Tubing	1 per 3 mo
X	Non Disposable Filter	1 per 6 mo	X	Disposable Filter	2 per 1 mo

Other Instructions *(Check all that apply)*

	Link Physician to Patient ☐ Resmed ☐ Respironics ☐ F&P
	Compliance Report 45-60 days from set up date
	Overnight pulse ox on PAP therapy in _____ weeks

Physician Signature		Date	
Physician Name		Phone	
NPI #		Fax	