

ORDER FORM

Name: _____ DOB: _____ Gender: Male Female Date: _____

Address: _____ City: _____ St: _____ Zip: _____ Phone: _____

Estimated LON: 99 Months (lifetime) **OR** _____ Face-to-Face Needs Assessment Date: _____ Height: _____ Weight: _____

Diagnosis:

- | | | | |
|---|--|---|--------------|
| <input type="checkbox"/> ALS (G12.21) | <input type="checkbox"/> Chronic Bronchitis (J41.0) | <input type="checkbox"/> Hypoxemia (R09.02) | Other: _____ |
| <input type="checkbox"/> Asthma, Extrinsic (J45.20) | <input type="checkbox"/> COPD (J44.9) | <input type="checkbox"/> Lung Cancer (C34.90) | Other: _____ |
| <input type="checkbox"/> Asthma (J45.____) | <input type="checkbox"/> CVA (I63.50) | <input type="checkbox"/> OSA (G47.33) | Other: _____ |
| <input type="checkbox"/> Central Sleep Apnea (G47.31) | <input type="checkbox"/> Emphysema (J43.9) | <input type="checkbox"/> Pulmonary Fibrosis (J84.10) | Other: _____ |
| <input type="checkbox"/> CHF (I50.9) | <input type="checkbox"/> Hypoventilation Syndrome (G47.35) | <input type="checkbox"/> Resp Failure, Unspecified (J96.00) | Other: _____ |

RESPIRATORY EQUIPMENT

Dosing Instructions:

- O₂ Concentrator (E1390) **OR** _____ LPM via Nasal Cannula **OR** Mask **OR** PAP Device **OR** Invasive Vent
- O₂ Portable Gaseous System (E0431) _____ Continuous **OR** Exercise/Exertion **OR** Hours of Sleep Only
- (incl oxygen contents) **OR**: _____ Conserving Device
- Nebulizer Compressor (E0570)w/ disp filter (2 per 1 mo) and reusable filter (1 per 3 mos) (if app) & w/disp admin set (2 per 1 month) + neb set (2 per 1 mo) **OR** w/ Mask (1 per 1 mo) + Neb Set (2 per 1 mo); **OR** w/ Reusable Admin Set (1 per 6 mos). Medication Used in Nebulizer: _____

SLEEP THERAPY

- CPAP (E0601): _____ cmH₂O *Ramp set to patient comfort on any PAP device unless otherwise ordered: _____*
- Auto CPAP (E0601): Min: _____ cmH₂O Max: _____ cmH₂O
- BiPAP (E0470): IPAP: _____ cmH₂O EPAP: _____ cmH₂O
- Auto BiPAP (E0470): Max Press: _____ cmH₂O Max IPAP: _____ cmH₂O Max EPAP: _____ cmH₂O
- RAD w/BU (E0471): IPAP: _____ cmH₂O EPAP: _____ cmH₂O Backup Rate: _____
- ASV (E0471): Max Press: _____ cmH₂O Min EPAP: _____ cmH₂O Max EPAP: _____ cmH₂O
- PS Min: _____ cmH₂O PS Max: _____ cmH₂O Backup Rate: _____

Mask Interface: (choose only 1 interface – substitution permitted)

- Nasal Mask (1 per 3 months) (A7034) & Nasal Mask Cushion (2 per month) (A7032)
- Nasal Pillow Mask (1 per 3 months) (A7034) & Nasal Pillow Cushion (2 pair per month) (A7033)
- Full Face Mask (1 per 3 months) (A7030) & Full Face Mask Cushion (1 per month) (A7031)
- Oral Mask Interface (1 per 3 months) (A7044) & Oral Mask Cushion (2 per month) (A7028)
- Combo Oral/Nasal Mask Interface (1 per 3 months) (A7027) with Oral Cushion (2 per month) (A7028) & Nasal Pillows (2 per month) (A7029)

Accessories:

- Heated Humidifier (E0562)
- Standard Tubing (1 per 3 months) (A7037)
- Chinstrap (1 per 6 months) (A7036)
- Humidifier (Passover) (E0561)
- Heated Tubing (1 per 3 months) (A4604)
- Filter: Disposable (2 per month) (A7038)
- Humidifier Chamber (1 per 6 months) (A7046)
- Headgear (1 per 6 months) (A7035)
- Filter: Non-disposable (1 per 6 months) (A7039)

DIAGNOSTIC

- Overnight Oximetry on Room Air **OR**
- Sleep Screening w/AHI
- Other: _____

WHEELCHAIR & ACCESSORIES

- Standard (K0001)
- General Use Seat Cushion (E2601) & Back Cushion (E2611) <22" wide
- Heel Loops (E0951) (x2 for pair)
- Lightweight (K0003)*
- General Use Seat Cushion (E2602) & Back Cushion (E2612) >22" wide
- Wheel Lock Extensions (E0961) (x2 for pair)
- Heavy Duty (K0006)*
- Elevating Leg Rests (pair) (K0195)
- Anti-tippers (E0971) (x2 for pair)
- Extra Heavy-Duty (K0007)*
- Safety Belt (E0978)

**unable to self-propel in standard wheelchair*

HOSPITAL BED & ACCESSORIES

- Semi-Electric¹(E0261) w/Therapeutic Foam Mattress (E0184)
- Other: _____
- Trapeze (free standing) (E0940)
- Trapeze (bed attached) (E0910)
- Patient Lift (E0630)

¹In addition to meeting fixed height bed criteria, patient's medical record must document condition requires frequent and/or immediate changes in body position.

AMBULATORY AIDS

- Walker (Folding) (E0135)
- Walker (Heavy Duty w/Brakes)² (E0147)
- Crutches (alum or non-wood) (pair) (E0114)
- Walker (Folding w/ Wheels) (E0143)
- Walker (Heavy Duty) (E0148)
- Cane (E0100)
- Walker (w/Wheels + Seat) (E0143 +E0156)
- Bedside Commode (E0163)
- Quad Cane (E0105)

²Must have a second qualifying diagnosis other than obesity

OTHER EQUIPMENT: _____

ATTACH THE FOLLOWING (AS APPLICABLE)

- Test Results (Oximetry, ABG, Sleep Study)
- Physician's Notes (from medical record documenting face-to-face needs assessment and expected benefit from equipment ordered above; physician must sign and date notes)
- Patient Demographics Sheet and Insurance Card

PRESCRIBED BY INFORMATION

Name: _____ NPI: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescribed By Signature: _____ Date: _____