Total Home Health
RESPIRATORY & MEDICAL EQUIPMENT

2100 Landmeier Rd | Elk Grove Village, IL 60007
PHONE: 847-915-3536 | FAX: 847-931-7138

Written Order Prior to Delivery PAP

Patient Name	Insurance ID/Group
Address	Insurance Name Insurance Phone
Phone	Order Date
DOB	Height/Weight
Number of Refills (i.e. 99=lifetime)	ICD-10/Diagnosis

Oxygen

☐	Oxygen Concentrator, E1390 PO2 level (*BCBS pt only*): _____ ***Select one of the following options in boxes below if patient needs portability:***	**Prescription**: LPM: _____ Hrs/Day:_____ Via: ☐ Nasal Cannula ☐ Mask
☐	Portable System, gaseous, E0431 & Oxygen contents, gaseous, E0443	☐ 24 hours/continuous
☐	Homefill system, gaseous, K0738	☐ With exertion
☐	Portable Oxygen Concentrator, E1392	☐ Bleed into PAP device

☐ Heated Humidifier, E0562		
☐ CPAP at _______, E0601	-OR-	☐ Auto CPAP at _______ - _______, E0601
☐ Bilevel at _________ / _________, E0470	-OR-	☐ Auto Bilevel at _______________, E0470
☐ Bilevel ST _______ IPAP, ________ EPAP, _______ BPM, E0471	-OR-	☐ Bilevel ST at _________________, E0471
☐ ASV _______ EPAP, _______ PS min, _______ PS max, _______rate, E0471		
☐ ASV/AVAPS, E0471 (indicate settings): _______		

Interface/Machine Supplies: Please select from columns below

Full Face Interface	**Nasal Mask Interface**	**Nasal Pillow Interface**
☐ ALL ITEMS BELOW	☐ ALL ITEMS BELOW	☐ ALL ITEMS BELOW
☐ Full Face mask, A7030 (1/3 month)	☐ Nasal Mask, A7034 (1/3 month)	☐ Nasal Pillow Mas, A7034 (1/3 month)
☐ Cushions, A7031 (1/month)	☐ Nasal Cushions, A7032 (2/month)	☐ Nasal Pillows, A7033 (2/month)
☐ Headgear, A7035 (1/6 months)	☐ Headgear, A7035 (1/6 months)	☐ Headgear, A7035 (1/6 months)
☐ Chinstrap, A7036 (1/6 months)	☐ Chinstrap, A7036 (1/6 months)	☐ Chinstrap, A7036 (1/6 months)
☐ Filter-Disposable, A7038 (2/month)	☐ Filter-Disposable, A7038 (2/month)	☐ Filter-Disposable, A7038 (2/month)
☐ Filter-Non-disposable, A7039 (1/6 month)	☐ Filter-Non-disposable, A7039 (1/6 month)	☐ Filter-Non-disposable, A7039 (1/6 month)
☐ Heated Tubing, A4604 (1/3 month)	☐ Heated Tubing, A4604 (1/3 month)	☐ Heated Tubing, A4604 (1/3 month)
☐ Water Chamber, A7046 (1/6 month)	☐ Water Chamber, A7046 (1/6 month)	☐ Water Chamber, A7046 (1/6 month)

Other ____

Please attach the following:

- Progress notes/face to face evaluation indicating patient need for prescribed equipment
- Patient demographics sheet
- Diagnostic Sleep Study
- Titration Sleep Study (required for Medicaid)

In my opinion, the supplies ordered are both reasonable and necessary for the treatment of this patient's condition per accepted standards of medical practice and are not prescribed for convenience. My signature below certifies the medical need for these items for this patient. This form must be SIGNED and DATED by the prescribing Physician prior to dispensing supplies and medical equipment.

For Medicare patients: I have reviewed diagnostic sleep study and verified it is scored off of 4% desaturation per CMS guidelines.

Physician Name		Physician NPI	
Physician Fax		Physician Phone	
Physician Signature	No stamps please – not valid by law	Date	

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