

# REQUEST FOR SERVICES: CPAP/OXYGEN/NEBULIZER

## PATIENT INFORMATION *(Complete the following or send patient's demographic sheet)*

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

Sex M F

Weight \_\_\_\_\_

Height \_\_\_\_\_

DOB \_\_\_\_\_

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work/Mobile Phone

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Insurance

\_\_\_\_\_  
Facility

### Therapy Services Requested :

\_\_\_\_ E0601 CPAP @ \_\_\_\_\_ cm w/htd.humid.Ramp: \_\_\_\_\_ EPR \_\_\_\_\_

Mask selection:

(leave blank for Pat.Preference)

\_\_\_\_ E0470 BiPAP @ \_\_\_\_\_

IPAPA/

EPAP w/Htd.Humid.Ramp:

EPR

\_\_\_\_ E0471 RAD @ \_\_\_\_\_

IPAP/

EPAP w/Htd.Humid. Rate:

bpm Ramp:

EPR:

\_\_\_\_ E0601 APAP @ \_\_\_\_\_ P max/ \_\_\_\_\_ p min w/htd.humid Ramp: \_\_\_\_\_ EPR \_\_\_\_\_

\_\_\_\_ E0471 Adapt S/V @ \_\_\_\_\_ PS max/ \_\_\_\_\_ PS min EEP- \_\_\_\_\_ w/htd.Humid.

\_\_\_\_ 99503 Therapist Consult/CPAP Rescue

\_\_\_\_ E1390- OXYGEN CONCENTRATOR

\_\_\_\_ E0431- PORTABLE GASEOUS OXYGEN

\_\_\_\_ E1392-PORTABLE OXYGEN CONCENTRATOR

\_\_\_\_ E0570- NEBULIZER, WITH COMPRESSOR

\_\_\_\_ A7015- AEROSOL MASK

\_\_\_\_ A7006- ADMINISTRATION SET, WITH SMALL VOLUME FILTERED PNEUMATIC NEBULIZER.

OTHER(specify): \_\_\_\_\_ DX Code: \_\_\_\_\_ 327.23

\_\_\_\_ Other: \_\_\_\_\_ (specify)

Prescriber Certification: I certify the above therapy is medically necessary and that the information above is accurate to the best of my knowledge

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Office contact \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI # \_\_\_\_\_ DEA# \_\_\_\_\_

Physician Address: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

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