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 # _____

FAX TO : 713-661-4828

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