AHM AMERICAN HOME MEDICAL
A Division of BP GAMMA MEDICAL

754 Roble Rd ◆ Suite 180 ◆ Allentown, PA 18109
Phone: 610-443-3014 Fax: 610-443-3074

Detailed Written Order

Duration of Prescription - 99=Lifetime

ORDER DATE: _____

Patient Name: **Date of Birth:**

Please select a primary diagnosis

- ☐ G47.33 Obstructive Sleep Apnea
- ☐ G47.31 Central/Complex Sleep Apnea
- ☐ G47.37 Complex Sleep Apnea
- ☐ Other: _____

AHI/RDI: _____ **If AHI/RDI is LESS THAN 15, please select a secondary diagnosis below**

- ☐ G47.30 Hypersomnia with Sleep Apnea, Unspecified
- ☐ I25.9 Chronic Ischemic Heart Disease
- ☐ G47.9 Excessive Daytime Sleepiness
- ☐ G31.84 Impaired Cognition
- ☐ I10 Hypertension
- ☐ G47.00 Insomnia
- ☐ Z86.73 Hx of Stroke
- ☐ F39 Mood Disorder

☐ **E0601 CPAP** ☐ **E0562 Heated Humidifier** **CPAP Set** Pressure:_____ cmH20 **Auto Set** Auto Pap Min Pressure _____ cmH20 Auto Pap Max Pressure _____ cmH20	☐ **E0470 Bi-Level** ☐ **E0562 Heated Humidifier** IPAP Max Pressure _____ cmH20 EPAP Min Pressure _____ cmH20	☐ **E0470 Auto Bi-Level** ☐ **E0562 Heated Humidifier** IPAP Max Pressure _____ cmH20 EPAP Min Pressure _____ cmH20 Pressure Support Min _____ cmH20 Pressure Support Max _____ cmH20
☐ **E0471 Auto SV Bi-Level** ☐ **E0562 Heated Humidifier** IPAP Max Pressure _____cmH20 EPAP Min Pressure _____ cmH20 EPAP Max Pressure _____ cmH20 PS Min _____ cmH2020 PS Max _____ cmH20 Rate _____	☐ **E0471 BIPAP AVAPS** ☐ **E0562 Heated Humidifier** Mode: ☐ S/T ☐ T ☐ PC IPAP Min Pressure _____ cmH20 IPAP Max Pressure _____ cmH20 EPAP Pressure _____ cmH20 VT _____ mL Rate _____ BPM	☐ **E0471 Auto ST Bi-Level** ☐ **E0562 Heated Humidifier** IPAP Pressure _____ cmH20 EPAP Pressure _____ cmH20 Rate _____

***Special Instructions**

Please check all applicable supplies:

- ☐ *Heated Tubing (A4604) 1 per 3 month*
- ☐ *Disposable filters (A7038) 2 per 1 month*
- ☐ *Non Disposable Filter (A7039) 1 per 6 months*
- ☐ *Headgear (A7035) 1 per 6 months*
- ☐ *Chin Strap (A7036) 1 per 6 months*
- ☐ *Water Chamber (A7046) 1 per 6 months*
- ☐ *Other:* _____

Please choose one of the following mask options

ensuring ***all items within*** are checked.

(AHM is authorized to fit patient with mask of their choice)

- ☐ *Full Face Mask (A7030) 1 per 3 months*
- ☐ *Full Face Cushion (A7031) 1 per month*

OR

- ☐ *Nasal Mask (A7034) 1 per 3 months*
- ☐ *Nasal Cushion (A7032) 2 per month*
- ☐ *Nasal Pillows (A7033) 2 per month*

I, the undersigned, certify that the above prescribed equipment and supplies are reasonable and necessary according to acceptable medical standards in the treatment of this condition. I confirm that this patient meets the criteria for coverage as indicated above.

Physician Name (Printed): _____ Physician NPI: _____

Physician Signature (no stamps): _____ Date: _____