PRESCRIPTION/VERIFICATION OF MEDICAL NECESSITY

Patient: _____ **DOB**:_____

DIAGNOSIS: g47.33 Obstructive Sleep Apnea :_X_ Unspecified Sleep Apnea: 780.57

APAP or CPAP: ___X____ BIPAP:_____

SETTINGS:_____HUMIDIFIER:_____

CPAP MASK/INTERFACE, Patient Preference: __X____

ALL RELATED SUPPLIES:___X____

Replacement on the following:

Full Face Mask (A7030)	Headgear (A7035)	Oral Interface (A7044)
Full Face Cushion (A7031)	Chinstrap (A7036)	Humidifier Chamber (A7046)
Nasal Mask (A7034)	Tubing (A7037)	Filters (A7039)
Mask Cushion (A7032)	Disposable Filters (A7038)	
Nasal Pillows (A7033)	Heated Humidifier tubing (A4604)	

The named patient was diagnosed as indicated. Treatment and supplies for this condition is considered mandatory rather than elective for a long term to lifetime duration (99 months).

Provider signature:_____ Date: _____
NPI#_____License#:_____
Address: _____
_____
Phone:_____Fax:_____

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