HCS Health Care Solutions
Phone: 610-544-6023 Fax: 866-851-5198
12 Creek Parkway, Suite 400
Boothwyn, PA 19061

CPAP/BiPAP/Oxygen/Supplies Prescription Form

Patient name: _____ DOB: _____

Patient address: _____ Phone #(s): _____

Insurance: _____ Policy #: _____

Referring physician: _____ Referral contact name: _____

Referral address: 1151 Old York Rd, Suite 200 Phone: 215-957-9250

Abington, PA 19001 Fax: 215-957-9254

Diagnosis

- ☐ **G47.33** Obstructive sleep apnea, AHI: _____
- ☐ **G47.31** Central sleep apnea
- ☐ **Other:** _____

Secondary diagnosis

- ☐ Hypertension
- ☐ History of stroke
- ☐ Coronary artery disease
- ☐ Mood disorders
- ☐ Impaired cognition
- ☐ Excessive daytime sleepiness

Order status: ☐ New patient ☐ Change in order ☐ Renewal ☐ Discontinue

PAP equipment ordered

- ☐ **E0601** CPAP Pressure: _____ cm H_2O Ramp (start/time): _____/_____ minutes Flex/EPR: ☐1 ☐2 ☐3
- ☐ **E0601** AutoCPAP Low: ____ High: ____ cm H_2O Ramp (start/time): _____/_____ minutes Flex/EPR: ☐1 ☐2 ☐3
- ☐ **E0470** BiPAP Pressure: ____/____ cm H_2O Ramp (start/time): _____/_____ minutes Flex/EPR: ☐1 ☐2 ☐3
- ☐ **E0470** AutoBiPAP Emin: _____ Imax: _____ PSmin: _____ PSmax: _____ Ramp (start/time): _____/_____ minutes Flex/EPR: ☐1 ☐2 ☐3 *(For fixed delta, set min & max to same setting, max setting 8cm)*
- ☐ **E0471** ASV Max pressure: _____ EPAPmin: _____ EPAPmax: _____ PSmin: _____ PSmax: _____ cm H_2O Rate: auto/____ BPM I-Time: ____ sec Ramp (start/time): _____/_____ minutes Flex/EPR: ☐1 ☐2 ☐3
- ☐ **E0562** Heated humidifer
- ☐ **E1390** Supplemental oxygen Liters per minute: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Patient interface (select 1 type of mask)

- ☐ Fit to full face mask *1 per 3 months x 1 year*
- ☐ Fit to nasal mask *1 per 3 months x 1 year*
- ☐ Fit to nasal pillows *1 per 3 months x 1 year*
- ☐ **A7031** Replacement full face mask cushion *1 per month x 1 year*
- ☐ **A7032** Replacement nasal mask cushions *2 per month x 1 year*
- ☐ **A7033** Replacement nasal pillows *2 per month x 1 year*

Accessories (select 1 type of tubing)

- ☐ **A7035** Headgear *1 per 6 months x 1 year*
- ☐ **A7036** Chinstrap *1 per 6 months x 1 year*
- ☐ **A7037** Tubing (standard) *1 per 3 months x 1 year*
- ☐ **A4604** Tubing (Heated) *1 per 3 months x 1 year*
- ☐ **A7038** Filters (Fine) *2 per month x 1 year*
- ☐ **A7039** Filters (Gross) *1 per 6 months x 1 year*
- ☐ **A7046** Humidifier chamber *1 per 6 months x 1 year*

Refills: ☐ None ☐ 1-year supply ☐ Lifetime - 99

Physician signature: _____ Date: _____

Physician name (printed): _____ Physician NPI: _____