

CPAP/BiPAP Referral Checklist / Simple Order Form

v1025

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Patient Name: _____

DOB: _____

Phone # _____

Please use the checklist below, and send all required documents, so we can provide equipment or supplies to your patient without delay. For any questions, please call (808) 261-8885 8-4:30, M-F

CHECKLIST	<p align="center">Initial CPAP:</p> <ol style="list-style-type: none"> 1. ___ Signed Prescription/order form with pressure settings and "Heated Humidifier & Heated Tube" 2. ___ ALL Sleep Studies (must include the diagnostic sleep study or home sleep test <i>and</i> any titration studies) 3. ___ Progress Notes addressing sleep/OSA (many insurers require notes <i>BEFORE</i> the sleep test) 4. ___ Patient Demographics we take all insurance <u>except</u> Medicare part B, Kaiser, VA 	<p align="center">Replacement CPAP</p> <p align="center">for established PIM customer <i>(If new to PIM, use <u>transfer</u> section)</i></p> <p align="center">broken machines > 5 years <i>or</i> restart/change to BiPAP</p> <ol style="list-style-type: none"> 1. ___ Prescription/order 2. ___ Progress notes describing need for continued use of CPAP therapy 							
	<p>Transfer <i>from a different vendor</i> (replacement machine or CPAP re-supply)</p> <p>we will need ALL of the following:</p> <table style="width:100%; border: none;"> <tr> <td style="width: 30%;">1. ___ All 4 items for initial CPAP:</td> <td>a) ___ Signed Prescription/order</td> </tr> <tr> <td></td> <td>b) ___ ALL Sleep Studies</td> </tr> <tr> <td></td> <td>c) ___ Progress Notes</td> </tr> <tr> <td></td> <td>d) ___ Patient Demographics</td> </tr> </table> <p align="center">-Plus-</p> <ol style="list-style-type: none"> 2. ___ Compliance records from old machine from previous vendor <p><small>*Please advise patient they may need to provide history and details about old machine from the previous vendor</small></p>		1. ___ All 4 items for initial CPAP:	a) ___ Signed Prescription/order		b) ___ ALL Sleep Studies		c) ___ Progress Notes	
1. ___ All 4 items for initial CPAP:	a) ___ Signed Prescription/order								
	b) ___ ALL Sleep Studies								
	c) ___ Progress Notes								
	d) ___ Patient Demographics								

ORDER FORM	<p>To use this as an order form, fill out the following: Order Date: _____</p>
	<p><input type="checkbox"/> CPAP/Auto-CPAP, pressure: _____ cm H₂O with Heated Humidifier & Heated tubing & supplies (E0601, E0562, A4604), with mask fit to pt preference (A7027-A7039)</p>
	<p><input type="checkbox"/> BiPAP/ Auto-BiPAP, pressure: _____ cm H₂O with Heated Humidifier & Heated tubing & supplies (E0470, E0562, A4604), with mask fit to pt preference (A7027-A7039)</p>
	<p><input type="checkbox"/> Other: _____</p>
	<p>Prescriber's Signature: _____ Date: _____</p> <p>Prescriber's Name: _____ NPI# _____</p> <p>Length of need: <u>99</u> months Prescriber's phone# _____ Prescriber's fax# _____</p>

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