Pacific Island Medical

156-B Hamakua Dr. Kailua, HI. 96734

Phone 261-8885 **Fax 261-8896**

BILEVEL WITH RATE Prescription
(ASV or BiPAP ST)

Patient's Name: _____ Date: _____

DOB: _____

Diagnosis: _____

(Dx must include Central Sleep Apnea, Complex Sleep Apnea, or Treatment Emergent Sleep Apnea for insurance coverage of a unit with a backup rate)

Please fax the following documents (insurance requirement):

____ Sleep Study ____ Notes prior to Sleep Study ____Patient Demographics

Equipment Ordered:

_____**BILEVEL ST (E0471)** IPAP: _____ EPAP: _____cmH_2O; BACKUP RATE:_____ bpm
with Heated Humidification/ tube & mask per pt preference

_____ **ASV / Auto-ASV (E0471)** Min EPAP: ____ Max EPAP: _____ Min PS: ___ Max PS: ____ cmH_2O
with Heated Humidification/ tube & mask per pt preference

_____ **other:**

Comments:

_____

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____