HEARTSTRONG sleep therapy

Home Sleep Study • CPAP • BiPAP • ASV • Supplies

CPAP & Bi-Level Order Form

Fax orders to 832.442.5505 • Call 832.770.3200

New Hope is a Heartstrong Company
9450 Grogans Mill • Suite 155
The Woodlands • Texas 77380

Patient Information

Patient Name: _____ Order Date: _____

DOB: _____ Best Contact Number: _____

Referral Office Information

Physician Contact: _____ NPI# _____

Phone: _____ Fax: _____

Version 06.07.17

1 DIAGNOSIS

- ○ Obstructive Sleep Apnea Syndrome (G47.33)
- ○ Central Sleep Apnea Syndrome (G47.37)

Length of Need: 99 months

2 THERAPY

- ○ CPAP or APAP (E0601) — Pressure or Pressure Range: _____ CM/H20
- ○ BiLevel PAP Or Auto BiLevel (E0470) — IPAP _____ EPAP _____ PS _____
- ○ BiLevel ST w/ Backup (E0471) — IPAP _____ EPAP _____ BU Rate _____
- ○ ASV (E0471) — EPAP _____ Min PS _____ Max PS _____

3 HUMIDIFIER

- ○ Patient Preference
- ○ Heated Humidifier (E0562)

4 CPAP MASK

- ○ CPAP Mask, Patient Preference
- ○ Other: _____ Size: _____

5 SUPPLIES

- ○ All Related Supplies
- ○ Check Here if Supply Order **ONLY**

The following dispensable equipment is necessary for the proper use of the equipment and is not a part of the CPAP, BiLevel, BiLevel ST, BiLevel SV or AVAPs machine when purchased and needs to be replaced on a regular basis.

○ Full Face Mask (A7030) 1 per 6 months	○ Full Face Cushion (A7031) 1 per month	○ Nasal Mask (A7034) 1 per 6 months
○ Nasal Cushion (A7032) 1 per month	○ Nasal Pillows (A7033) 1 per month	○ Headgear (A7035) 1 per 6 months
○ Standard Tubing (A7037) 1 per 6 months	○ Disposable Filters (A7038) 2 per month	○ Non-Disposable Filters (A7039) 1 per 6 months
○ Heated Tubing (A4604) 1 per 6 months	○ Humidifier Chamber (A7046) 1 per 6 months	○ Chinstrap (A7036) 1 per 6 month

The above named patient was diagnosed as indicated. Due to the potentially dangerous consequences of disturbed sleep and sleep deprivation, which include the possibility of falling asleep in critical situations, treatment of this condition is considered mandatory rather than elective, on a nightly basis for a longterm to lifetime duration (99 months) This order confirms that the equipment is medically necessary for treatment.

With your approval, we will contact a DME provider that will very benefits, contact the patient and notify you of any problems with authorization

Physician Signature Required	Physician Name (Printed)	Date