30150 Telegraph Rd., Suite 185, Bingham Farms, MI 48025
P: 877-363-7133 F: 248-282-9049 info@thedmesource.com

PAP PRESCRIPTION ORDER FORM

Name: _____ Order Date: _____

Address: _____ City: _____

State: _____ Zip Code: _____ DOB: _____

Phone: _____ Email: _____

Insurance: _____ID #: _____

Length of Need (99=Lifetime): _____

Diagnosis/ICD-10: ❑ G47.33 (OSA) ❑ Other: _____

Order Information:

❑ CPAP (E0601) ❑ APAP (E0601) ❑ BPAP (E0470) ❑ Auto BPAP (E0470)

Pressure settings (cm H_2O): _____

❑ Heated Humidifier (E0562)

❑ A4604 Heated Tubing (4/year)
❑ A7030 Full Face Mask (4/year)
❑ A7031 Full Face Cushion (1/month)
❑ A7032 Nasal Cushion (2/month)
❑ A7033 Nasal Pillow (2/month)
❑ A7034 Nasal/Pillow Mask (4/year)
❑ A7035 Headgear (2/year)
❑ A7036 Chin Strap (2/year)
❑ A7037 Tubing (4/year)
❑ A7038 Disposable Filter (2/month)
❑ A7039 Non-Disposable Filter (2/year)
❑ A7046 Humidifier Chamber (2/year)

I certify that the above prescribed equipment is medically indicated and supports standards of medical practice for this diagnosis.

Ordering Doctor: _____ **NPI:** _____

Signature: _____ **Date:** _____

Facility: _____ **Phone:** _____ **Fax:** _____

Please fax completed form to 248-282-9049