Arizona Medical Equipment & Supply LLC

DETAILED WRITTEN ORDER

PATIENT INFORMATION:

Last Name ____________ First Name ____________ DOB ____________

Address ____________ City ____________ State ____________ Zip Code ____________ Phone Number ____________

DIAGNOSIS
ICD-10 CODE ________ ________ ________ ________ **LENGH OF NEED**: __________ in Months (99 = Lifetime)

PAP EQUIPMENT & SUPPLIES *(SELECT ALL THAT APPLY)* **AHI:** ___________ **Test Date:** ____________________

__ **CPAP** (E0601) @ ____ cmH2O | __ **AUTO-CPAP** (E0601) @ ____ to ____ cmH2O | __ **BiPAP** (E0470) @ _____/ _____

___ **BiPAP-ASV** (E0471) @ EPAP ___ Min ___ Max PS ___ Min ___Max Max Pres ___ cmH2O Rate ___ BPM

___ Heated Humidifier (E0562) 1 per 5 years

___ Full Face Mask (A7030) 1 per 3 months **OR** ___ Nasal Mask (A7034) 1 per 3 months ___ Headgear (A7035) 1 per 6 months

___ Full Face Cushion (A7031) 1 per mo **OR** ___ Nasal Cushion (A7032) 2 per mo **OR** ___ Nasal Pillow (A7033) 2 per mo

___ Disposable Filter (A7038) 2 per month ___ Filter (A7039) 1 per 6 months ___ Chin Strap (A7036) 1 per 6 months

___ Tubing (A7037) 1 per 3 months **OR** ___ Heated Tubing (A4604) 1 per 3 months ___ Water Chamber (A7046) 1 per 6 months

OXYGEN EQUIPMENT & SUPPLIES

___ O2 Concentrator (E1390) @ ____ LPM __ Continuous __During Sleep __ During sleep w/PAP device __ With Exercise

___ Portable Gaseous O2 System (E0431) ____ Regulator ____ OCD (O2 Conserve Device) to maintain SPO2 @ 90% or greater

METHOD OF DELIVERY
___ Nasal Cannula (A4615) ____ Bleed in with PAP Device _____ Trach System (A4620)

QUALIFYING TESTING **(Must be documented in the chart notes)** **TEST DATE:** ________________________

AT REST	***DURING SLEEP***
_____ O2 Sats on RA at rest	____ Lowest O2 Sats During Sleep (Min.2 hours of recording) _____ Duration at or below 88%

EXERCISE TEST (6 Minute Walk Test)

____ O2 Sats on RA at rest _____ O2 Sats on RA during exercise _____ O2 Sats on O2 @ ____ Lpm with exercise

OVERNIGHT OXIMETRY ORDER
__ On Room Air __ On Room Air with CPAP/BiPAP @ ________ cmH2O __ on O2 @ _____ Lpm

SVN WITH COMPRESSOR *MEDS TO BE DISPENSED:* ________________________________

____ SVN Compressor (E0570) ____ Disposable Neb Kit (A7003) 2 per month ____ Neb aerosol mask (A7015) 1 per month

CHEST COMPRESSION GENERATING DEVICE

___ AFFLOVEST (E0483)

NON-ELECTRIC PERCUSSIVE DEVICE

___ ACCAPELLA FLUTTER VALVE (E0484)

PHYSICIAN INFORMATION *(MUST BE PECOS CERTIFIED)*

Printed Name ____________ MD/DO/NP/PA-C ____________ Facility Name ____________

Address ____________ City ____________ State ____________ Zip Code ____________ Phone ____________ Fax ____________

I certify that I am the treating physician as identified on this form. By signing below, I authorize the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable, and is not being prescribed for convenience. I will maintain a copy of this order in my medical record and make it available to Medicare, their authorized agents or other insurer, if required. I further certify that the signature below is, in fact, my personal pen and ink signature and is not a stamp, or this document has been electronically signed and meets the CMS standards for electronic signature as required by law.

MD/DO/NP/PA-C Signature ____________ NPI Number ____________ Date ____________

ONCE COMPLETED, FAX TO AMES AT

PHOENIX AREA- 623-266-7254 **PRESCOTT AREA– 928-771-0376**