Smart Medical
PRODUCTS & SERVICES

CPAP / BIPAP / OXYGEN / PAP SUPPLIES
PRESCRIPTION FORM

P: 717-399-7451
F: 717-399-8128

PATIENT INFORMATION

Patient Name : _____ DOB: ____ / ____ / ____

Patient Phone : _____ Order Date: ____ / ____ / ____

DIAGNOSIS

- ☐ OSA – G47.33, AHI: _____
- ☐ Central Sleep Apnea — G47.31
- ☐ Other: _____

SECONDARY DIAGNOSIS

- ☐ Hypertension
- ☐ History of Stroke
- ☐ Coronary Artery Disease
- ☐ Mood Disorders
- ☐ Impaired Cognition
- ☐ Excessive Daytime Tiredness

EQUIPMENT ORDER STATUS

☐ New Patient ☐ Change in Order ☐ Renewal ☐ Discontinue

EQUIPMENT ORDERED

- ☐ CPAP (E0601) Pressure: ____ cm H2O Ramp (Start / Time): ____ / ____ minutes Flex / EPR: 1 2 3
- ☐ AutoCPAP (E0601) Low: ____ High: ____ cm H2O Ramp (Start / Time): ____ / ____ minutes Flex / EPR: 1 2 3
- ☐ BiPAP (E0470) Pressure: ____ / ____ cm H2O Ramp (Start / Time): ____ / ____ minutes Flex / EPR: 1 2 3
- ☐ AutoBiPAP (E0470) Emin: _____ Imax: _____ Ramp (Start / Time): ____ / ____ minutes Flex / EPR: 1 2 3
  PSmin:_____ PSmax: _____ (For fixed Delta set min & max to same setting, max setting 8 cm)
- ☐ BiPAP ST (E0471) Max Pressure:___ EPAPmin:___ EPAPmax:____ PSmin:____ PSMax:____cmH2O
  Rate: Auto/ ___ BPM I-Time ___ sec Ramp (Start / Time): ___ / ___ minutes Flex: 1 2 3
- ☐ Heated Humidifier (E0562)
- ☐ Supplemental Oxygen (E1390) @ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 liters/minutes

PATIENT INTERFACE: *Select Only 1 Type of Mask - Medicare Will Void Rx If Multiple Masks Are Selected*

- ☐ Mask: _____ q1 / 3 months x 1 year
  - ☐ Fit Full Face Mask A7030 ☐ Fit to Nasal Mask A7034 ☐ Fit to Nasal Pillows A7034
- ☐ Replacement Full Face Mask Cushion (A7031) – q1 / 30 Days x 1 year
- ☐ Replacement Nasal Mask Cushions (A7032) – q2 / 30 Days x 1 year
- ☐ Replacement Nasal Pillows (A7033) – q2 / 30 Days x 1 year

ACCESSORIES: *Select 1 Type of Tubing. New Set Ups Come With Heated Tubing*

- ☐ Headgear (A7035) q1 / 6 months x 1 year ☐ Chinstrap (A7036) q1 / 6 months x 1 year
- ☐ Tubing (Standard) (A7037) q1 / 3 months x 1 year ☐ Tubing (Heated) (A4604) q1 / 3 months x 1 year
- ☐ Filters (Fine) (A7038) q2 / 1 month, q1 / 6 months x 1 year ☐ Filters (Gross) (A7039) q2 / 3 months x 1 year
- ☐ Humidifier Chamber (A7046) q1 / 6 months x 1 year

REFILLS:

☐ None ☐ 1/Year Supply ☐ Lifetime = 99 (As allowed by patient's health insurance plan)

Practitioner's Name: _____

Ordered By : _____ Order Date : _____

NPI : _____

Phone : _____ Fax : _____

_____
Practitioner's Signature

_____
Date