**Prescription / Letter of Medical Necessity**

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supplier Information

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PAPmaster.com

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI#:1275618811

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID #: 260028585

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: Obstructive Sleep Apnea (OSA) G47.33 Central Sleep Apnea (CSA) G47.31

 Hypersomia G47.10 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Due to the above diagnosis, PAP unit is required for this patient. I, the undersigned certify that this prescription is reasonable and necessary according to the accepted standards in treatment and is not prescribed as a convenience device. The above named patient, if left untreated, remains at risk for cardiac arrhythmia, high blood pressure, and other symptoms associated with obstructive sleep apnea.**

**Additionally, the use of this device will improve sleep architecture disruption resulting from obstructive sleep apnea, as well as long term reversal of symptoms (such as excessive daytime somnolence, irritability, difficulties in concentration, falling asleep inappropriately, forgetfulness and depression). Documentation supporting this diagnosis are available upon request. PAPmaster.com is authorized to dispense the equipment brand that ensures patient’s comfort and compliance.**

**DME Equipment required:**

* **CPAP (E0601) Pressure : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cmH20**
* **AutoPAP (E0601) Pressure : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cmH20**
* **BiPAP Spontaneous (E0470) Pressure IPAP :\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cmH20 Pressure EPAP :\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cmH20**
* **BiPAP Auto (E0470) Pressure IPAP: \_\_\_\_\_\_\_\_\_\_\_\_ cmH20 Pressure EPAP :\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cmH20**
* **BiPAP, auto SV, at IPAP min pressure \_\_\_\_\_cm H20 and max Pressure \_\_\_\_cm H20 and EPAP Pressure \_\_\_\_cm H20 , Back up rate \_\_\_\_\_, BPM \_\_\_ , T1\_\_\_\_, Rise Time\_\_\_\_\_\_\_.**

**Humidifier:**

* **Patient Preference (E0562)**

**CPAP Mask:**

* **CPAP Mask Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Patient Preference**

**Supplies:**

* **All Related supplies ( Tubing, Filters, Water Chamber)**

**Length of use \_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE FAX TO : 408-414-7010**

**or email to: info@papmaster.com**