Americare™
Respiratory Services

PHYSICIAN ORDER

Physician Name _____ NPI _____

Address _____ City _____ PECOS ☐ YES ☐ NO

State _____ Zip _____ Telephone _____ Fax _____

Patient Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Cell Phone _____ ☐ Male ☐ Female

PAP SUPPLIES

PAP MACHINE

QTY	CODE	ITEM	FREQ	CODE	PAP MACHINE	PRESSURE INDICATES MACHINE SELECTED (cmH_2O)
1	A4604	Heated Tubing	3 mos	E0601	CPAP	_____
2	A7032	Nasal Cushion	1 mo	E0601	AUTO CPAP	_____
2	A7033	Nasal Pillow/ Seals	1 mo	E0470	BIPAP	IPAP _____
1	A7034	Nasal Application Device	3 mos			EPAP _____
1	A7035	Headgear	3 mos	E0470	AUTO BIPAP	IPAP_____ EPAP_____
1	A7036	Chinstrap	3 mos			PS _____
1	A7037	Tubing	1 mo			
2	A7038	Disposable Filters	1 mo			
1	A7039	Non-Disposable Filters	3 mos			
1	A7030	Full Face Mask	3 mos			
1	A7031	Face Mask Interface	1 mo			
1	A7046	Humidifier Chamber	6 mos			
	E0562	Heated Humidifier				

DIAGNOSIS	Obstructive Sleep Apnea (327.23)	Excessive Daytime Sleepiness (780.59)

LENGTH OF NEED 99 MONTHS (LIFETIME)

PHYSICIAN NAME PRINTED _____ **DATE OF ORDER** _____

PHYSICIAN SIGNATURE _____ **START DATE** _____
(If different from date of order)

RETURN FAX (866) 481-8359

MPORTANT WARNING: The documents accompanying this transmission contain health and business information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately for the return or destruction of these documents.

Revised February 11, 2015