betternight

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Section 1: Physician & Patient Information

Referral Date:

Patient Name:

Patient Phone:

Patient Date of Birth:

Referring Physician:

Physician Address, City, State, Zip:

Physician Fax:

National Provider Identifier:

Certification Type: ☐ Initial ☐ Renewal

Est Length of Need: 99 Months 1-99 (99=Lifetime)

Section 2: Select Equipment & Supplies Prescribed

(Please select one from each section below)

- ☐ CPAP (E0601) 1 every 5 years
- ☐ APAP (E0601) 1 every 5 years
- ☐ Bi-level (E0470) 1 every 5 years
- ☐ Bi-level w/ Back-up Rate (E0471) 1 every 5 years

- ☐ Humidifier – Heated (E0562) 1 every 5 years

- ☐ Tubing w/ Int. Heating (A4604) 1 per 3 months
- ☐ Tubing (A7037) 1 per 3 months

- ☐ Full Face Mask (A7030) 1 per 3 months
  - Full Face Mask Cushion – (A7031) 1 per month
- ☐ Nasal Mask Interface (A7034) 1 per 3 months
  - Nasal Cushion (A7032) 2 per month
  - Nasal Pillows (A7033) 2 pairs per month

- ☐ Headgear (A7035) 1 per 6 months
- ☐ Chin Strap (A7036) 1 per 6 months
- ☐ Filter, Disposable (A7038) 2 per month
- ☐ Non-Disposable Filter (A7039) 1 per 6 months
- ☐ Humidifier Chamber (A7046) 1 every 6 months

Mask Type: _____

Machine Type: _____

☐ FOR SUPPLIES ONLY

Section 3: Diagnosis (Please attach patient demographics, recent consult notes and sleep test)

Patient Prognosis:

☐ Severe ☐ Poor ☐ Fair ☐ Good ☐ Other

Questions:

Date of most recent sleep study: _____

The AHI is: _____

Setting(s) for device: _____ +/- 2cm H20

_____ +/- 2cm H20

Other: _____

Diagnosis:

Patient Diagnosis Codes:

☐ OSA (G47.33) ☐ Other: _____

☐ Complex SA (G47.37) ☐ Central SA (G47.37)

ICD -10 Code: _____

Secondary Diagnosis (if primary is OSA and AHI is 5-14):

☐ Excessive daytime sleepiness ☐ Insomnia

☐ Ischemic heart disease ☐ Stroke

☐ Mood Disorder ☐ Hypertension

Provider's Signature:

Date: