PROGRESSIVE HOME MEDICAL Setting the Standard

Fax 480.895.2949

Phone 480.802 0202

Referred by_____

******Valley Wide Service******

Patient's Name: _____Date of Birth: _____

Address: _____City: _____ Zip:_____

Patient's Phone: (Home) _____ (Cell) _____ (Work) _____

******Please Send a Copy of All Insurance Cards With This Form******

❒ C-PAP _____ cm H_2O ❒ Bi-PAP IPAP _____ EPAP _____

❒ Bi-PAP ST IPAP _____ EPAP _____ BR _____

❒ Bi-PAP ASV IPAP Max _____ EPAP Min _____ EPAP Max_____ Min PS _____

MASKS:

- [X] E0562 Heated Humidifier
- [X] A7034 Nasal Application Device (quarterly)
- [X] A7032 Seals/Cushions/Flaps (bi-weekly)
- [X] A7030 Full Face Mask (quarterly)
- [X] A7031 Face Mask Cushion/Flap (monthly)
- [X] A7034 Nasal Application Device (quarterly)
- [X] A7033 Nasal Pillows (bi-weekly)
- [X] A7027 Mask (quarterly)
- [X] A7028 Cushions (bi-weekly)
- [X] A7029 Nasal Pillows (bi-weekly)
- [ ] A7044 Oral Interface (quarterly)
- [X] A7031 Face Mask Cushion/Flap (monthly)

ACCESSORIES:

- [X] A7035 Headgear (semi-annually)
- [X] A7036 Chin Strap (semi-annually)
- [X] A7038 Filters-Disposable (bi-weekly)
- [X] A7039 Filters-non-Disposable (bi-weekly)
- [ ] A9279 Data Card
- [ ] E1399 Misc. Equipment (wireless modem)
- [ ] A7046 Replacement Water Chamber (Semi-Annually)

TUBING:

- [X] A7037 Tubing (monthly)
- [ ] A4604 Heated Tubing (quarterly)

Please mark at least one appropriate diagnosis:

- [ ] Obstructive Sleep Apnea (ICD10 G47.33)
- [ ] Primary Central Sleep Apnea (ICD10 G47.31)
- [ ] COPD (ICD10 J44.9)
- [ ] Hypersomnia w/Sleep Apnea (ICD10 G47.30)
- [ ] Central /Complex Sleep Apnea (ICD10 = G47.37)
- [ ] Other _____

Length of Need: [X] Lifetime _____

The AHI or RDI is greater than or equal to 5 and less than or equal to 15 events per hour with a minimum of 10 events and documentation of additional symptoms noted in the patient's medical record. Please check documented symptoms below:

❒ Excessive Daytime Sleepiness/Hypersomnia ❒ Impaired Cognition ❒ Mood Disorders ❒ Hypertension

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity on this form is true, accurate, and complete, to the best of my knowledge.

PHYSICIAN'S SIGNATURE: _____DATE: ____/_____/_____

Print Physician's Name _____ NPI _____