MEDICAL WEST

Farmington
P: 573-747-0008
F: 573-747-0018

St. Louis
P: 314-993-8100
F: 314-993-8101

Washington
P: 636-390-4040
F: 636-390-9699

WOPD - Written Order Prior to Delivery | Respiratory

Date: _____

Patient Name: _____ DOB: _____ HT:_____ WT:_____

Case Manager/Office Contact: _____ Phone: _____

**** Please remember to send Face to Face (Office Visit) Notes! ****

OXYGEN & VENTILATOR

☐ E1390 Concentrator ☐ K0738 Homefill/Conserver ☐ E1392 Port Concentrator ☐ E0431 Port Oxygen/Conserver ☐ E0434 Liquid Port
☐ E0443 Portable Gas Contents ☐ E0444 Portable Liquid Contents ☐ E0450 Vent Invasive w/no Pressure Support
☐ E0465 Vent Invasive with Pressure Support ☐ E0466 Vent Non-Invasive with Pressure Support

List applicable ICD-10 codes: _____

O2 Orders: _____LPM Rest _____LPM with Exertion _____LPM Nocturnal ☐ Bleed Into PAP

Ventilator Settings/Pressure: _____

NOCTURNAL OXIMETRY TEST

Nocturnal Oximetry Testing ☐ Room Air ☐ On O2_____LPM ☐ On PAP_____CM Pressure

List applicable ICD-10 codes: _____

PAP AND SUPPLIES

☐ E0601 CPAP ☐ E0470 BiPAP ☐ E0471 BiPAP ST/ASV ☐ E0562 PAP Heater ☐ All Related Supplies
☐ OSA G47.33 ☐ Primary Central Sleep Apnea G47.31 ☐ Central Sleep Apnea in Conditions Classified Elsewhere G47.37 ☐ COPD J44.9

Other ICD-10 codes: _____

PAP Pressure

☐ CPAP Settings _____ Cm/H_2O
☐ CPAP Auto Settings _____ to _____ Cm/H_2O
☐ Bi-Level Therapy Settings _____/_____ Cm/H_2O
☐ Bi-Level Auto Therapy Setting IPAP Max _____ EPAP Min _____ Min PS _____ Max PS _____ (3-8 cm)
☐ Bi-Level W/Back Up Rate _____/_____ Cm/H_2O _____ Rate
☐ Auto SV Therapy Setting Max P _____ EPAP Min _____ EPAP Max _____ PS Min _____ PS Max _____ Rate _____
Breath Rate (Off, Auto, _____ BPM)

NEBULIZER THERAPY

☐ E0570 Nebulizer ☐ A7005 Non Disp Kit 1/6 mo ☐ A7003 Disp Kit 2/1 mo ☐ A7013 Disp Filter 2/1 mo ☐ A7015 Aerosol Mask 1/1 mo

List applicable ICD-10 codes: _____

I certify that the above referenced item(s) is(are) medically necessary for my patient, based upon diagnosis.
I have documentation to support this in the patient's file.

– REQUIRED INFORMATION –	Length of Need: ☐ 99 Months ☐ Other_____
Doctor Name *Printed*:	Doctor NPI:
Doctor Signature:	Date:

***** Please No Stamped Signatures *****

**** MD Must Date ****