Home Medical Equipment and Oxygen
450 State Route 664 North • P.O. Box 997 • Logan, Ohio 43138
Phone: (740) 385-6177 or 1-800-423-3615 •FAX: (740) 385-0474
242 W. 6th Ave. • Lancaster, Ohio 43130
Phone: (740) 652-9250 or 1-800-423-3625 •FAX: (740) 652-9253

Verification of bi-level therapy
Order -BiPAP S or ST
Physician Order

Dear Doctor,

This form is submitted to you to verify the order received for bi-level therapy *with or without a backup rate* (BiPAP-S or S/T) for conditions *other than obstructive sleep apnea..*

Patient____ Initial Date of Service:________________
Renewal Date:______________________

BIPAP Therapy may be approved for *one* of the following *three* types of medical conditions *other than* OSA:
Restrictive Thoracic Disorder, e.g neurologic disorder:
Diagnosis (ICD-9 Code and Description)____
Required Testing: Negative Inspiratory Force (NIF):______________or Vital Capacity:_____________

Severe COPD: Specific Diagnosis (ICD-9 Code and Description):__________________________________
____
Required Testing: PC02________; Five Minutes of Nocturnal *Continuous* 02 Desaturation at 88% or below:____Yes___No
Obstructive Sleep Apnea (and treatment with CPAP) has been considered and ruled out?____Yes____No

Central Apnea: (ICD-9 Code):____
Required Testing: Facility Based Sleep Study Documenting *Central* Apnea:_____Yes______No
AHI_________; Central Apneas/Hypopneas greater than 50% of total AHI______Yes____No
Did Central Apnea/Hypopnea occur with CPAP (Complex Sleep Apnea) _____Yes_____No
Has *Obstructive* Sleep Apnea been considered and excluded as a *Primary* Component of this Patient's Sleep Disorder?____Yes____No; Symptoms of excessive sleepiness/disrupted sleep ____Yes____No

Is Supplemental Oxygen Ordered?______Yes____No; 02 Flowrate with BiPAP:___________L/minute

Bi-PAP S/T Settings:

IPAP__________cmH20; EPAP_________cmH20; Back-up Rate:_________breaths/minute
Ramp:_________minutes;Bi-Flex Option:________Yes___________No
Humidifier:____________Heated________________Unheated

Mask Specifications (if any):____
Chinstrap:_____________Yes____________No

Length of Need:________3 months______6 months______LIFETIME

Physician:____NPI________________________
Address:____
Physician Signature:____Date:_______________

Mjf/BiPAP S/T; 01/07