Apnix Equipment & Supplies

Leading The Way In Sleep Disorder Diagnostics & Equipment

Durable Medical Equipment
Letter of Medical Necessity
Physician Order

Fax: (713) 349-9634

1

Patient: _____ Gender: _____ D.O.B.: _____

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Work: _____ Cell : _____

2

Therapy Equipment: ☐ New Setup ☐ Pressure Change **Start Date:** _____

☐ CPAP ____ cm*

* ***Set at optimal pressure settings per most current study recommendations unless otherwise indicated.***

☐ AutoPAP ____min/____max cm*

☐ BiPAP ____ IPAP/____EPAP cm*

Diagnosis: _____

☐ G47.33 Obstructive Sleep Apnea

☐ G47.31 Primary Central Sleep Apnea

ACHC ACCREDITED

Apnix is accredited by ACHC Accreditation Commission for Healthcare.

☐ BiPAP Auto ____ IPAP min/____IPAP max cm & ____ EPAP min/____EPAP max cm*

☐ AutoSV (RAD-E0471) w/ HH (E0562) @ IPAP min/_____ max/_____ & EPAP/____ cm* & Rate: AUTO bpm

☐ Ramp: _____ Heated Humidifier: ☐ **Duration:** lifetime (99 months)

3

Compliance Monitoring Required: ☐ **Leak** ☐ **AHI** ☐ **Patient Usage** ☐ **Pressure Setting**

Compliance Download at: ☐ **30 Days** ☐ **60 Days** ☐ **90 Days**

4

Supplies:

☐ **ALL RELATED SUPPLIES**

☐ **Mask, Nasal** (A7034: refill 1/3 mos)
☐ **Mask, Full Face** (A7030: refill 1/3 mos)
☐ **Mask Cushion, Nasal** (A7032: refill 1/1 mo)
☐ **Mask Cushion, Full Face** (A7031: refill 1/1 mo)
☐ **Mask Pillows, Nasal** (A7033: refill 2/1 mo)

☐ **Headgear** (A7035: refill 1/6 mos)
☐ **Chinstrap** (A7036: refill 1/6 mos)
☐ **Humidifier Chamber** (A7046: refill 1/6 mos)
☐ **Tubing** (A7037: refill 1/3 mos)
☐ **Tubing, Heated** (A4604: refill 1/3 mos)
☐ **Filter, Non-Disposable** (A7039: 1/6 mos)
☐ **Filter, Disposable** (A7038: 2/1 mo)

The above name patient was diagnosed as indicated. Due to the potentially dangerous consequences of sleep disordered breathing and sleep deprivation, which include the possibility of falling asleep in critical situations. **Treatment of this condition is considered mandatory rather than elective for a long term to lifetime duration (99 months) on a nightly basis.**

5

Ordering Physician: _____ NPI: _____

Address: _____ Zip _____

Phone: _____ Fax: _____

6

Physician's Signature: _____ **Date:** _____

Note to Physicians Office: *Please include copies of the patients insurance card(s) and office visit notes. Thank you for allowing Apnix to Provide your patient with our remarkable patient care!*

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