HANDI MEDICAL SUPPLY

Standard Written Order: Positive Airway Pressure Device

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:

Diagnosis (ICD-10) *(Enter ICD-10 code)*

_____ _____ _____ _____

Please select the items that you are ordering in each section below

☐ BiLevel/Auto (E0470) ☐ BiLevel ASV/AVAPS (E0471) ☐ CPAP/Auto (E0601) ☐ Humidifier (E0562)

_____ cm H_2O Ramp: _____

Min: _____ cm H_2O Max: _____ cm H_2O

IPAP _____ cm H_2O EPAP _____ cm H_2O Rate: _____

Mask Interfaces – Please select only one system *(Dispensing Qty is listed in parenthesis)*

Full Face:

☐ A7030 (1 per 3 months) Full Face
☐ A7031 (1 per 1 months) Replacement Full Face Mask Interface
☐ A7035 (1 per 6 months) Headgear used with PAP device

Oral/Nasal:

☐ A7027 (1 per 3 months) Oral/Nasal Combination Mask
☐ A7028 (2 per 1 months) Replacement Oral Cushion for Oral/Nasal Combination Mask, each
☐ A7029 (2 per 1 months) Replacement Nasal Pillow for Oral/Nasal Combination Mask, pair

Nasal Cushion:

☐ A7034 (1 per 3 months) Nasal Interface (mask or cannula type) used with PAP device
☐ A7032 (2 per 1 months) Cushion for Nasal Mask
☐ A7035 (1 per 6 months) Headgear used with PAP device

Nasal Pillow:

☐ A7034 (1 per 3 months) Nasal Interface (mask or cannula type) used with PAP device
☐ A7033 (2 per 1 months) Replacement Pillow for Nasal Cannula, pair
☐ A7035 (1 per 6 months) Headgear used with PAP device

Tubing – Select only one *(Dispensing Qty is listed in parenthesis)*

☐ A4604 (1 per 3 months) Tubing with integrated heating element ☐ A7037 (1 per 3 months) Replacement Tubing

Other – Check all that apply *(Dispensing Qty is listed in parenthesis)*

☐ A7036 (1 per 3 months) Chinstrap
☐ A7046 (1 per 6 months) Water Chamber
☐ A7038 (2 per 1 months) Disposable Filter
☐ A7039 (1 per 6 months) Non-Disposable Filter

1. Order Date: _____

2. Length of Need: _____
Leaving blank presumes Lifetime (99 months)

3. Please attach the following *(as applicable)*

☐ **Test Results** (Sleep Study, ABG) ☐ **Patient Demographic Sheet** ☐ **Copy of Patient's Insurance**
☐ **Physician's Note** (from medical records of patient, documenting requirement for equipment as well as physician's assessment and expected benefit from the equipment ordered above. Physicians are required to sign and date notes.)

4. _____ _____
Physician/NP/PA/Medical Practitioner Signature Date

Signer must match Prescriber Information at the top of this form, or be updated below:

Print New Prescriber Name: NPI:

