American HomeCare Equipment
Main Address: 3200 N 29th. Ave. Hollywood, FL 33020
Phone: (954) 772-5052 Fax: (954) 772-5288
West Palm Beach Address: 6252 S. Congress Ave. Lantana, FL, 33462
Phone: (561) 469-2090 Fax: (561) 894 -5296

Email: customerservice@ahcequip.com
Parachute / Careport / Go Scripts / DME Scripts

Guideline Order for CPAP / BIPAP Machine

The following documentation is required by Medicare for us to be able to supply a CPAP / BIPAP Machine

1) **Prescription (Rx) stating the following: (e.g.)**
   - Type of CPAP Machine (Regular,Auto, BiPAP).
   - Setting
   - Type of Mask,Tubing,Filters or mask of Patients choice.
   - NPI and Signed by Doctor.

2) **Physician progress notes or Face to Face Prior to Sleep Study**

3) **Sleep Study Signed by Doctor**
   - If AHI is 4 or below - Patient does not qualify
   - If AHI is between 5 & 14 - Patient must have a secondary diagnosis like
     - ☐ Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia
     - ☐ Hypertension, Ischemic heart disease or history of stroke
   - If AHI is 15 or above - Patient qualifies
     - ☐ Needs to have OSA (Obstructive Sleep Apnea)

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CPAP | BIPAP | OXYGEN | PAP Supplies Prescription Form

Patient Information:

Patient Name: _____ Date of Birth: ____/____/____
Patient Phone: _____ Order Date: ____/____/____
Insurance: _____ Policy #: _____

Referral Information:

Referral Name: _____ Contact Name: _____
Address: _____
Phone: ___-___-____ Fax: ___-___-____

Diagnosis:

☐ OSA – G47.33, AHI: _____
☐ Central Sleep Apnea – G47.31
☐ Other: _____

Secondary Diagnosis:

☐ Hypertension ☐ Mood Disorders
☐ History of Stroke ☐ Impaired Cognition
☐ Coronary Artery Disease ☐ Excessive Daytime Tiredness

Equipment Order Status: ☐ New Patient ☐ Change in Order ☐ Renewal ☐ Discontinue

Equipment Ordered:

☐ CPAP (E0601)	Pressure: ____ cm H2O	Ramp (Start /Time): ____ / ____ minutes	Flex / EPR: 1 2 3
☐ AutoCPAP (E0601)	Low: ____ High: ____ cm H2O	Ramp (Start / Time): ____ / ____ minutes	Flex / EPR: 1 2 3
☐ BiPAP (E0470)	Pressure: ____ / ____ cm H2O	Ramp (Start / Time): ____ / ____ minutes	Flex / EPR: 1 2 3
☐ AutoBiPAP (E0470)	Emin: ____ Imax: ____	Ramp (Start / Time): ____ / ____ minutes	Flex / EPR: 1 2 3
	PSmin: ____ PSmax: ____	(For fixed Delta set min & max to same setting, max setting 8 cm)	
☐ BiPAP ST (E0471)	Max Pressure:____ EPAPmin:____ EPAPmax:____ PSmin:____ PSMax:____ cmH_2O		
	Rate: Auto/ ____ BPM	I-Time ____ sec	Ramp (Start /Time): ____ / ____ minutes Flex: 1 2 3

☐ Heated Humidifier (E0562)

☐ Supplemental Oxygen (E1390) @ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 liters/minute

Patient Interface: (Please Select Only 1 Type of Mask - Medicare Will Void Rx If Multiple Masks Are Selected)

☐ Mask: _____ q1 / 3 months x 1 year
☐ Fit Full Face Mask A7030 ☐ Fit to Nasal Mask A7034 ☐ Fit to Nasal Pillows A7034
☐ Replacement Full Face Mask Cushion (A7031) – q1 / 30 Days x 1 year
☐ Replacement Nasal Mask Cushions (A7032) – q2 / 30 Days x 1 year
☐ Replacement Nasal Pillows (A7033)– q2 / 30 Days x 1 year

Accessories: (Please Select 1 Type of Tubing. New Set Ups Come With Heated Tubing)

☐ Headgear	(A7035)	q1 / 6 months x 1 year
☐ Chinstrap	(A7036)	q1 / 6 months x 1 year
☐ Tubing (Standard)	(A7037)	q1 / 3 months x 1 year
☐ Tubing (Heated)	(A4604)	q1 / 3 months x 1 year
☐ Filters (Fine)	(A7038)	q2 / 1 month, q1 / 6 months x 1 year
☐ Filters (Gross)	(A7039)	q2 / 3 months x 1 year
☐ Humidifier Chamber	(A7046)	q1 / 6 months x 1 year

Refills: ☐ None / ☐ 1-year supply / ☐ Lifetime = 99 (As allowed by patient's health insurance plan)

Name: _____ **Signature:** _____

Date: ____/____/____ **NPI:** _____ **Order Date:** ____/____/____

*Your signature confirms the accuracy of the information provided on this form