Hayat
Home Medical Equipment

Switch to a New Age in Life.

3518 W. 95th St., Evergreen Park, IL 60805

Phone: 708-422-2300
Fax: 708-422-5966

PAP / POSITIVE AIRWAY PRESSURE PRESCRIPTION

Physician order for PAP therapy and related equipment/supplies. Please complete all applicable fields, sign and date the order.

1. PATIENT INFORMATION

Patient Name	_____
Date of Birth	_____ Sex: ■ M ■ F ■ Other
Address	_____
City / State / ZIP	_____
Phone	_____ Email: _____

2. INSURANCE / MEDICARE INFORMATION

Primary Insurance	_____
Member / ID #	_____
Group #	_____ Medicare #: _____
Secondary Insurance	_____
Member / ID #	_____

3. DIAGNOSIS / MEDICAL NECESSITY

Primary Diagnosis / ICD-10-CM	**Secondary Diagnosis / ICD-10-CM**
_____ ICD-10: _____	_____ ICD-10: _____

■ Obstructive Sleep Apnea ■ Central Sleep Apnea

4. PAP DEVICE ORDER

Device	**Order / Setting**	**Initial / Replacement**
■ CPAP / Fixed PAP	Pressure: _____ cm H_O	■ Initial ■ Replacement
■ APAP / Auto-CPAP	Range: _____ to _____ cm H_O	■ Initial ■ Replacement
■ BiPAP / BPAP	IPAP: _____ EPAP: _____ cm H_O	■ Initial ■ Replacement
■ Other PAP	Settings: _____	■ Initial ■ Replacement

5. EQUIPMENT & SUPPLIES

■ PAP device	■ Disposable filters	■ Heated tubing
■ Full-face mask	■ Nasal mask	■ Nasal pillows
■ Headgear	■ Chin strap	■ Other: _____
■ Mask cushions/pillows	■ Water chamber	■
■ Heated humidifier	■ SD/data card if applicable	■

6. SLEEP STUDY / CLINICAL INFORMATION

Sleep Study Date	_____

AHI / RDI	_____
Oxygen Desaturation	_____ %
Relevant Clinical Notes	_____ _____

7. LENGTH OF NEED / ADDITIONAL ORDERS

Length of Need: ■ 99 months / Lifetime ■ _____ months ■ Other: _____

Additional physician instructions: _____

_____

8. PHYSICIAN INFORMATION & SIGNATURE

Prescribing Physician	**NPI**
_____	_____
Practice / Facility	**Phone**
_____	_____
Physician Signature	**Date**
_____	_____

Important: This form is a physician order template. Coverage and documentation requirements vary by payer. The prescribing practitioner is responsible for ensuring that the order and supporting clinical documentation meet applicable payer and medical-necessity requirements.

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PLEASE FAX OVER OFFICE NOTES, SLEEP STUDY AND NOTE PRIOR TO SLEEP STUDY ALONE WITH THE PRESCRIPTION