



BAYSIDE - STURGEON BAY
1437 Egg Harbor Road
Sturgeon Bay, WI 54235
TEL (920) 746-2158
Hours: M-F 8:00am - 5:00pm

BAYSIDE - GREEN BAY
2476 S Oneida St, Suite 120
Green Bay, WI 54304
TEL (920) 965-8303
Hours: M-Th 9:00 - 3:30

BAYSIDE - APPLETON
1717 E Calumet St, Suite C
Appleton, WI 54915
TEL (920) 560-1810
Hours: M-F 8:00 - 4:30

FAX referral/Rx to us:

(920) 746-2138

Prescription / Provider Order Form / Letter of Medical Necessity for Sleep Apnea Supplies

Patient Contact Information

Name:		Birthdate:
Address:		
City:	State:	Zip:
Phone:	Email:	

Physician Contact Information

Name:		Email
Address:		
City:	State:	Zip:
Phone:	Fax:	
National Provider Identification (NPI) Number:		

Diagnosis Code (Check 1 or both) and Sleep Study Findings

AHI From Sleep Study: Obstructive Sleep Apnea Central Sleep Apnea
 ICD-9: 327.23 ICD-10: G47.33 ICD-9: 327.27 ICD-10: G47.37

Please Indicate Type of PAP Equipment and Pressure (pressure is optional for Auto)

PAP Options: CPAP (E0601) Bi-Level (E0470) Bi-Level w/ RAD Back-up (E0471)
 Non-Auto: _____ cm H2O IPAP___ EPAP___ IPAP___ EPAP___
 Auto: 4 to 20 cm H2O

Supplies (check all that apply)

Humidification

<input type="checkbox"/> Mask and other necessary supplies (see list below)	<input type="checkbox"/> To include heated humidifier
<input type="checkbox"/> Check here to indicate other products _____	<input type="checkbox"/> Other _____
Default order is for 99 months, unless indicated here <input type="checkbox"/> Other _____	

Detailed List of Supplies Necessary for the Proper Operation of PAP Equipment.

- | | | |
|---------------------------|----------------------------------|--------------------------------|
| Full-Face Mask (A7030) | Headgear (A7035) | Oral Interface (A7044) |
| Full-Face Cushion (A7031) | Chinstrap (A7036) | Exhalation Port/Swivel (A7045) |
| Mask Cushion (A7032) | Tubing (A7037) | Humidifier Chamber (A7046) |
| Nasal Pillows (A7033) | Disposable Filters (A7038) | Non-Disposable Filters (A7039) |
| Nasal Mask (A7034) | Tubing w/Heating Element (A4604) | |

Other Comments:

Provider Signature: _____ Date: _____

(Must be one of the following: Doctor of Osteopathy, Medical Doctor, Psychiatrist, Physician's Assistant, Nurse Practitioner, Dentist, Orthodontist)