1800CPAP.COM

Prescription/Letter of Medical Need Request

The following patient has ordered CPAP supplies through 1800CPAP.com. Before we are able to release their order we do require that a valid prescription is on file. Please provide the requested information at your earliest convenience.

Please note that the pressure settings must be listed for the appropriate device.

Ordering Physician		**Patient Name**	
Phone Number		**Date of Birth**	
Fax Number		**Order Number**	

Select Therapy Device

- ☐ CPAP [E0601]
  - Pressure: _____ cm/H2O
  - Ramp: _____ mins.
  - EPR/Flex: _____
- ☐ AutoCPAP (APAP) [E0601]
  - Minimum Pressure: _____ cm/H2O
  - Maximum Pressure: _____ cm/H2O
  - Ramp: _____ mins.
  - EPR/Flex: _____
- ☐ Bi-Level/BiPAP [E0470]
  - IPAP Pressure: _____ cm/H2O
  - EPAP Pressure: _____ cm/H2O
  - Ramp: _____ mins.
  - EPR/Flex: _____
- ☐ BiPAP Auto [E0470]
  - IPAP Pressure: _____ cm/H2O
  - EPAP Pressure: _____ cm/H2O
  - Pressure Support: _____ cm/H2O
  - Ramp: _____ mins.
  - EPR/Flex: _____
- ☐ Bi-Level ST/BiPAP ST [E0471]
  - IPAP Pressure: _____ cm/H2O
  - EPAP Pressure: _____ cm/H2O
  - BPM: _____
  - Ramp: _____ mins.
  - EPR/Flex: _____
- ☐ BiPAP AutoSV [E0471]
  - IPAP Minimum Pressure: _____ cm/H2O
  - IPAP Maximum Pressure: _____ cm/H2O
  - EPAP Pressure: _____ cm/H2O
  - BPM: _____
  - Ramp: _____ mins.
  - EPR/Flex: _____
- ☐ Oxygen Concentrator
  - Flow Setting: _____ L/min

CPAP Mask/Patient Interface

- ☐ CPAP Mask Patient Preference
- ☐ CPAP Mask Mask Name : _____ Size_____

Supplies/Accessories

- ☐ Heated Humidifier [E0562]
- ☐ All related supplies necessary for proper use of the above described therapy device (i.e. filters, tubing, headgear, etc).

Duration of Use

- ☐ Lifetime (99 months)
- ☐ Limited Duration _____Years _____Months

Physician Signature: _____Date: ___/____/_____NPI: _____

PLEASE FILL IN ALL REQUIRED AREAS AND FAX TO 888-290-6188.

Ohio Sleep Awareness, LLC | 651 Reading Rd | Mason, OH 45040-1571
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