1800CPAP.COM Prescription/ Letter of Medical Need Request

Ordering Physician	
Practice Name	
Address	
Phone Number	
Fax Number	

Requesting DME Provider	Ohio Sleep Awareness LLC 1800CPAP.com
OH Respiratory License # OH Provider Tax ID#	HMEL 11385 26-0504270

Patient Name	
Date of Birth	

Your patient has purchased a CPAP or BiPAP machine, mask or supplies from 1800CPAP.com. Before we can release this order to your patient we must have a copy of their prescription on file. Please indicate pressure setting(s) so that we may expedite your patient's order. Please fill out below information and fax to (888) 290-6188.

Preferred CPAP Device Manufacturer: ☐ RESMED ☐ PHILIPS RESPIRONICS ☐ Fisher&Paykel HEALTHCARE ☐ Patient Preference

Select Therapy Device

- ☐ CPAP [E0601]
- ☐ AutoCPAP (APAP) [E0601]
- ☐ Bi-Level/BiPAP [E0470]
- ☐ Bi-Level ST/BiPAP ST [E0471]
- ☐ BiPAP AutoSV [E0471]
- ☐ VPAP Adapt SV [E0471]

Prescribed Pressure(s) or Pressure Range(s)

CPAP Mode: ________ cm/h2O _________ ramp time _______ EPR or Flex Setting

Auto CPAP (APAP) Mode: _______min cm/h2O to _______ max cm/h2O _______EPR or Flex

BiPAP/BiLevel Mode: _______IPAP cm/h2O _______ EPAP cm/h2O ______EPR or Flex

ASV Mode: ______Min ______Max _______Rate _________Max Pressure _______Max Support

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 FAX THIS FORM TO: 1-888-290-6188

1800CPAP.COM
Address: 651 Reading Rd | Mason, OH 45040
Ph: 1(800) 274-1366 Fax: 1(888) 290-6188
Visit us at www.1800CPAP. com