Clinician's Written Order: CPAP Therapy

PROVIDER: Sleep Metrics
15812 SW Upper Boones Ferry Rd
Lake Oswego, OR 97035-4066
Phone (503) 222-9777
FAX (503) 905-8562
Provider No.

PHYSICIAN: Colleen Amann ND
15875 SW 72nd Ave
Portland, OR 97224-7913
License # **NPI** 1548527724
Phone (503) 855-4341 **Fax** (833) 955-3574

PATIENT: Hayes, Hannibal
11575 SW PACIFIC HWY # 2382
TIGARD, OR 97223-8671
Phone (406) 909-2328
DOB 07/05/1989
Initial Date
Revised Date
Recertification
Length of Need (in months) 99
Policy UH601V1J

DIAGNOSIS

ICD-10 Code	Description
G47.33	Obstructive sleep apnea (adult) (pediatric)

EQUIPMENT/SERVICES

Qty Proc. Code Item Name/Narrative

ADDITIONAL MEDICAL INFORMATION

Auto-CPAP - E0601
Heated Humidifier - E0562
Modem- A9279
RT Evaluation and PAP Setup - CPT 94660

Please fit mask per patient preference at the time of setup.
Please replace the patient's accessories in accordance with their insurance payer's allowed schedule

Accessories:

Full Face Mask- A7030 (1 per 3 months)
Full Face Cushions- A7031 (1 per month)
Nasal Mask- A7034 (1 per 3 months)
Nasal Cushions- A7032 (2 per month)
Nasal Pillows- A7033 (2 per month)
Headgear- A7035 (1 per 6 months)
Climate tubing - A4604 (1 per 3 months)
Disposable filters - A7038 (2 per 1 month)
Reusable filters - A7039 (1 per 6 months)
Humidifier chamber - A7046 (1 per 6 months)
Chinstrap - A7036 (1 per 6 months)

Pressure Setting (cmH20):

5-20 cmH20

The above referenced patient has an absolute Medical Necessity for the item(s) listed above. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the standards of medical practice for this patient's condition.

Clinician Signature _____ **Date** _____

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