MARATHON VENTURES CORP

21 West Rd, Suite 105
Towson, MD 21204

Phone: 855-343-7799
Fax: 866.258.9465
Email: orders@mvcmed.com

PHYSICIAN'S ORDER

DATE: _____ ID#: _____

Patient Name: _____ DOB: _____

Patient Address: _____

Phone: _____ Gender: ☐M ☐F ☐Other

Dx:

- ☐ G47.33: Obstructive sleep apnea (adult) (pediatric)
- ☐ G47.31: Central sleep apnea (adult) (pediatric)
- ☐ Other: _____

Length of Need: 99

Dispense:

Choose ONE machine type:

☐ **E0601** ***APAP***
- ☐ Default pressure range 5-20
- ☐ Set to pressure: _____

☐ **E0601** ***CPAP***
Set to pressure: _____

☐ ***E0470 BiPAP***
Set to pressure _____
*Additional diagnosis (when applicable): _____

☐ ***E0471 BiPAP – ASV w/ Backup Rate***
Set to pressure _____
Timed settings _____
*Requires additional diagnosis: _____

Choose EITHER humidifier:

☐ **E0562** ***Heated Humidifier***

☐ **E0561** ***Non-heated Humidifier***

Choose ONE mask type:

☐ **A7030** ***Full Face Mask,*** 1 per 3 months
A7031 Full Face Cushion for (A7030), 1 per month

☐ **A7027** ***Oral/Nasal Combo Mask*****,** 1 per 3 months
A7028 Oral Cushion for (A7027), 2 per month
A7029 Nasal Pillows for (A7027), 2 per month

☐ **A7034** ***Nasal Mask*****,** 1 per 3 months
A7032 Nasal Cushion for (A7034), 2 per month
A7033 Nasal Pillows for (A7034), 2 per months

☐ **A7044** ***Oral Mask,*** ____ per ____ month(s)
**contact patient payer for quantity and frequency*

Choose ONE tubing:

☐ **A4604** ***Heated tubing****,* 1 per 3 months

☐ **A7037** ***Non-heated tubing***, 1 per 3 months

Supporting supplies:

☒ **A7036** ***Chin Strap****,* 1 per 6 months
☒ **A7038** ***Disposable Filter***, 2 per month
☒ **A7046** ***Humidifier Chamber*****,** 1 per 6 months

☒ **A7035** ***Headgear***, 1 per 6 months
☒ **A7039** ***Non-Disposable Filter*****,** 1 per 6 months

Physician's Name: _____ NPI: _____

Physician's Address: _____

Phone: _____ FAX: _____

Physician's Signature: _____ Date: _____

PLEASE FAX TO: 1-866-258-9465