

**PAP
PRESCRIPTION
FORM**



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

21 West Road STE 105 Towson, MD 21204

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: _____

Secondary Dx:

- ☐ Hypertension ☐ History of Stroke
☐ Coronary Artery Disease ☐ Mood Disorders
☐ Excessive Daytime Tired. ☐ Impaired Cognition
☐ Other: _____

PAP History: ☐ **New to Therapy**

☐ **Existing PAP User**

Length of Need: 99

Dispense:

Choose **ONE** machine type:

☐ **E0601 APAP**

- ☐ Default pressure range 5-20 cm H2O
☐ Set to pressure: Low _____ High _____ cm H2O

☐ **E0601 CPAP**

Set to pressure: _____ cm H2O

☐ **E0470 BiPAP**

IPAP: _____ EPAP: _____ cm H2O

*Additional diagnosis (when applicable): _____

☐ **E0471 BiPAP – ASV w/ Backup Rate**

IPAP: _____ cm H2O

EPAP Min: _____ EPAP Max: _____ cm H2O

PS Min: _____ PS Max: _____ cm H2O

Rate _____

*Requires Secondary Dx: _____

Choose **ONE** 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

☐ **A7034 Nasal Pillow Mask**, 1 per 3 months

A7033 Nasal Pillows for (A7034), 2 per month

☐ **Fit Upon Setup**

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