TODAYS DME INC

1312 Redwood Ave
Grants Pass OR 97527

Ph 541-249-9860
Fx 541-249-9859
melody.hannah@todaydme.com

Detailed Written Order

Patient Name:

Patient DOB:

Order Date:

☐ **Chart notes Attached** (chart notes must include the need for equipment being ordered) F2F Referral Chart notes for sleep study and Diagnostic Sleep Study

I, the undersigned, certify that the below prescribed equipment/supplies is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment". I have documented the following information and the need for this equipment in the patient's most recent chart notes.

Date of visit prior to order:

DIAGNOSIS (Check appropriate diagnosis below) Length of Need: ☐ 12 months ☐ 99 months

☐ OSA G47.33 ☐ CSA G47.31 Other

PAP Products & accessories are medically necessary (Check equipment/supplies ordered)

☐ APAP/CPAP (E0601) ☐ BIPAP (E0470) ☐ ASV (E0471) ☐ AVAPS (E0472) ☐ Supplies only

RX:

☑ Humidifier Heater (E0562)
☑ Heated Tubing (A4604)
☑ Non-Heated tubing (A7037)
☑ Water Chamber (A7046)
☑ Disposable Filter, 2 every month (A7038)
☑ Reusable filter, 1 every 3 months (A7014)

Mask Options

☑ Full Face Mask (A7030) ☑ Nasal/Pillow Mask (A7034) ☑ Headgear (A7035)
☑ Full Face cushion, 1 every month (A7031)
☑ Nasal cushion, 2 every month (A7032)
☑ Nasal Pillow, 2 every month (A7033)

Prescribing Physician's Information

Name & Credentials

NPI#

Telephone

Fax

Address

Signature

Signature Date