PAP THERAPY ORDERS &

CERTIFICATE OF MEDICAL NECESSITY

ultreia health
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F: 913-548-4201

Referring Contact Person _____

Phone _____ Date of order _____

PATIENT INFORMATION

Name _____ Contact info* Patient Alternative Contact

Address _____ Home phone _____ _____

_____ Cell phone _____ _____

DOB _____ Email _____ _____

check preferred contact method if known

DIAGNOSIS

☐ G47.33 Obstructive sleep apnea-Adult and child ☐ G47.31 Central Sleep Apnea ☐ G47.37 CSA other

ADDITIONAL DX **(if AHI 5-14)** ☐ Daytime sleepiness ☐ Impaired cognition ☐ Mood disorder ☐ Insomnia

☐ Hypertension ☐ Ischemic heart disease ☐ History of stroke

PAP DEVICE

☐ **AUTO CPAP**	Low pressure _____	High pressure _____	
☐ **CPAP**	Pressure _____		
☐ **AUTO BIPAP**			
ResMed	Min EPAP _____	Max IPAP _____	Pressure Support (PS) _____
Respironics	Min EPAP _____	Max IPAP _____	PS min _____ PS max _____
☐ **BIPAP**	EPAP _____	IPAP _____	
☐ **BIPAP with rate**	EPAP _____	IPAP _____	Rate_____/min
☐ **ADAPTIVE PRESSURE VENTILATION**			
ResMed	EEP _____	PS min _____	PS max _____
Respironics	Min EPAP _____	Max IPAP _____	PS min _____ PS max _____
		Back up Rate _____	PS min _____ PS max _____

☐ **Heated Humidifier**

PAP SUPPLIES *supplies are included in set up or replaced as needed

☐ Nasal mask	○ Interface	1 every 6 months
	○ Cushion	2 per month
	○ Headgear	1 every 6 months
☐ Nasal Pillows Mask	○ Interface	1 every 3 months
	○ Cushions	2 per month
	○ Headgear	1 every 6 months
☐ Full face Mask	○ Interface	1 every 3 months
	○ Cushion	1 per month
	○ Headgear	1 every 6 months
☐ Oro/Nasal Combo Mask	○ Interface	1 every 3 months
	○ Cushions (O/N)	2 per month
	○ Headgear	1 every 6 months

***Duration is for lifetime unless indicated otherwise** _____

○ Tubing-Standard	1 every 3 months
○ Tubing-Heated	1 every 3 months
○ Filters-Disposable	2 per month
○ Filters-Nondisposable	1 every 6 months
○ Chin Strap	1 every 6 months
○ Repl. Water chamber for humidifier	1 every 6 months

ORDERING PROVIDER

I certify that the item(s) prescribed above are medically necessary

Name_____ Signature _____

Address _____ NPI _____

_____ Date _____

PAP PARTNERS FOR LIFE