



# Supplies Only Order Request

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Phone: 207-992-2660 Fax: 207-992-2661

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

DIAGNOSIS: OBSTRUCTIVE SLEEP APNEA LENGTH OF NEED: 99 # MONTHS (99=LIFETIME)

MAILING ADDRESS: \_\_\_\_\_ CITY/TOWN \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

PRIMARY INSURANCE CARRIER: \_\_\_\_\_ ID# \_\_\_\_\_ GR# \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_ ID# \_\_\_\_\_ GR# \_\_\_\_\_

### INTERFACE

- EVALUATE VARIOUS MASK OPTIONS FOR OPTIMAL COMPLIANCE
- CUSHIONS, TUBING, CHIN STRAPS, WATER CHAMBERS AND FILTERS AS NEEDED
- HEATED HUMIDIFIER

### COMPLIANCE REPORT FREQUENCY

REPORTS GENERATED IF THE DEVICE HAS COMPLIANCE DATA CAPABILITY

- 2 WEEKS
- 30 DAYS
- 60 DAYS
- 90 DAYS
- OTHER \_\_\_\_\_
- Pulse Oximetry w/PAP device

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(PLEASE DO NOT USE SIGNATURE AND/OR DATE STAMPS)

⇔ (SLEEP WELL INTER-OFFICE USE ONLY) ⇐

### EQUIPMENT INFORMATION REQUIRED FROM MEDICARE RECIPIENTS

MEDICARE REQUIRES WE SUPPLY THEM WITH THE FOLLOWING INFORMATION FROM THE EQUIPMENT WHEN YOU ARE A SUPPLY ONLY CUSTOMER

MANUFACTURER: \_\_\_\_\_ MODEL OF DEVICE: \_\_\_\_\_ SERIAL NUMBER: \_\_\_\_\_

DEVICE HOURS: \_\_\_\_\_ DATE WHEN FIRST STARTED ON THERAPY: \_\_\_\_\_

DATE WHEN LAST NEW SUPPLIES WERE RECEIVED: \_\_\_\_\_

IF AVAILABLE, BRING YOUR MOST RECENT CPAP/BI-LEVEL MEDICARE EOB (EXPLANATION OF BENEFITS) STATEMENT

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