CONFIRMATION OF ORDER — CPAP/BiPAP & Supplies

PROVIDER: Home Health Solutions
501 East Sloan Street
Harrisburg, IL 62946

phone: 618-252-5349
fax: 618-252-2445

NPI: 1215337266
Tax ID #: 371124259

Patient: _____ **Date of Birth:** _____

Order Date: _____ **Insurance:** _____

Length of Need: 99 *(in months)*

Physician: _____ **NPI:** _____

DIAGNOSIS

ICD 10 Code	Description

EQUIPMENT/SERVICES

Quantity	Proc. Code	Item Name/Narrative
☐ 1	E0601	CPAP Pressure Set _____ CmH_2O
☐ 1	E0470	BiPAP Pressure Set: IPAP _____ CmH_2O / EPAP _____ CmH_2O
☐ 1	E0562	Heated Humidifier
☐ 1/3 mo.	A4604	Heated Tubing, 1 per 3 months
☐ 1/3 mo.	A7037	Non-Heated Tubing, 1 per 3 months *(Medicaid)*
☐ 1/6 mo.	A7039	Non-Disposable Filter, 1 per 6 months
☐ 2/1 mo.	A7038	Disposable Filter, 2 per 1 month
☐ 1/6 mo.	A7035	Headgear, 1 per 6 months
☐ 1/3 mo.	A7030	Full Face Mask, 1 per 3 months
☐ 1/3 mo.	A7034	Nasal Mask, 1 per 3 months
☐ 1/6 mo.	A7036	Chin Strap, 1 per 6 months

ADDITIONAL MEDICAL INFORMATION *(please read and check box before signing)*

☐ I, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment for this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and available upon request.

Physician Signature: _____ **Date:** _____