

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 ₂ O
1	E0470	BiPAP Pressure Set: IPAP CmH ₂ O / EPAP CmH ₂ O
1	E0562	Heated Humidifier
1/3 mo.	A4604	Heated Tubing, 1 per 3 months
1/3 mo.	A7027	Combination oral/nasal mask frame, 1 per 3 months
1/1 mo.	A7028	Oral cushion for combination mask, 1 per 1 month
2/1 mo.	A7029	Nasal pillows for combination mask, 2 per 1 month
1/3 mo.	A7037	Non-Heated Tubing, 1 per 3 months (<i>Medicaid</i>)
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
1/1 mo.	A7031	Full Face Mask Cushion, 1 per 1 month
1/3 mo.	A7034	Nasal Mask, 1 per 3 months
2/1 mo.	A7032	Nasal Mask Cushion, 2 per 1 month
2/1 mo.	A7033	Replacement Nasal Pillows, 2 per 1 month
1/6 mo.	A7036	Chin Strap, 1 per 6 months
1/6 mo.	A7046	Replacement Water Chamber, 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: _____