



Phone: 888-49-SLEEP (75337) Fax: 866-877-2714

Positive Airway Pressure Physician Supply Order Form

**Intake and Patient Demographic Information**

<b>Patient Name:</b>	<b>Date of Referral:</b>
<b>SSN:</b>	<b>DOB:</b>
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Person Making Referral:</b>	<b>Referral Phone Number:</b>
<b>Physician Name:</b>	<b>Physician Phone:</b>
<b>Patient's Home Address:</b>	<b>Home Phone:</b>
	<b>Work Phone:</b>
	<b>Cell Phone:</b>
<b>Emergency Contact (if known):</b>	<b>E.C. Phone:</b>
<b>Primary Insurance: Fallon Community Health Plan</b>	<b>Subscriber ID#:</b>
<b>Authorization #:</b>	<b>Group #:</b>
<b>Secondary Insurance:</b>	<b>Policy #:</b>
<b>Address:</b>	<b>Group #:</b>
<b>Sleep Lab Where Study Was Conducted:</b>	<b>Date of Study:</b>

Date Patient Received Supplies: \_\_\_\_\_ Released to Bill: \_\_\_\_\_

**Patient is requesting the following replacement supplies for their Positive Airway Pressure device.  
Replace all required positive airway pressure device supplies in the future, as needed.**

A7030 Full Face Mask: \_\_\_\_\_ Size: \_\_\_\_\_

A7034 Nasal Interface: \_\_\_\_\_ Size: \_\_\_\_\_

A7032 Replacement Cushion  A7033 Replacement Pillows

A7035 Headgear  A07037 Tubing for PAP Device  A7036 Chinstrap

A7046 Water Chamber (Humidifier Make & Model): \_\_\_\_\_

A9900 Tubing for Humidifier

A7038 #\_\_\_\_\_ Disposable Filters  A7039 Non-disposable Filter

Patient's Make & Model of PAP Equipment: \_\_\_\_\_

Other (specify): \_\_\_\_\_

**Length of Need:** Lifetime  Other: \_\_\_\_\_

Physician Signature

Date

License #