VITAL CARE OF MERIDIAN

Tailored Therapy, Trusted Care

DETAILED WRITTEN ORDER

Phone: 601.482.4003 Fax 601.482.3948

PLEASE ATTACH PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

PATIENT DEMOGRAPHICS			
DATE			
PATIENT NAME		DOB	
DEVICE		SETTING	
DIAGNOSIS		HCPCS	
AHI		FACE-TO-FACE EVAL	
LENGTH OF NEED	(MONTHS)		

Please provide the following supplies as needed:

___A7030 (full face mask 1 per 3 months)
___A7031 (full face mask cushion 1 per month)
___A7034 (nasal mask a per 3 months)
___A7032 (nasal cushion 2 per month)
___A7033 (nasal pillow 2 per month)
___A4604 (heated tubing 1 per 3 months)
___A7036 (chin strap 1 per 6 months)
___A7046 (humidifier chamber)
___A7035 (headgear 1 per 6 months)
___A7038 (disposable filters 2 per month)
___A7039 (reusable filter 1 per 6 months)
___E0562 (heated humidifier)
___E0601 (CPAP machine)
___E0470 (BiPAP machine)
___E0471 (BiPAP ASV/ST/AVAP machine)
___A7037 (tubing)

Is the patient's AHI>15 events per hour OR 5-15 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, or history of stroke?
_____YES _____NO

AHI is calculated based on a minimum of two hours of recorded sleep and calculated using the actual recorded hours of sleep? _____YES _____NO

PROVIDER SIGNATURE _____ DATE _____

PROVIDER NAME _____ NPI _____

PHONE _____ FAX _____