10481 164th Place
Orland Park, IL 60467
1-888-598-8515 Phone
1-708-364-0166 Fax

PHYSICIAN'S ORDER
CPAP AND SUPPLIES

Physician Consent Form for Durable Medical Equipment/CPAP Supplies

Physician: Your patient is requesting CPAP supplies for their sleep apnea therapy. Please authorize CPAP Wholesale to dispense these items by completing the following consent/authorization form.

Date: _____ New Patient: Yes☐ No☐ Replacement equipment only☐

Patient:_____ DOB: ___/___/___

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____

☐CPAP ☐Heated/Humidifier ☐Patient's Preferred Machine ☐Supplies (mask/tubing/filters, etc.)

Pressure Setting:_____cm

☐APAP ☐Heated/Humidifier ☐Patient's Preferred Machine

Pressure Setting: _____minimum cm _____ maximum cm

☐BIPAP ☐Heated/Humidifier ☐Patient's Preferred Machine

Pressure Setting: _____IPAP _____EPAP

☐Nasal mask ☐Full Face ☐Nasal Pillows ☐Patient's Preferred Mask

Diagnosis of Patient: ☐327.23 (OSA) ☐327.2 (Other Unspecified) ☐327.27 (CSA) ☐780.53 Hypersomnia w/sleep apnea

Length of Time Needed: 1-99 months (99=Lifetime) _____/months

Name of Ordering Physician:_____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax:_____ **NPI#:**_____

Physician's Signature:_____ Date:_____