Allied Medcor Services, Inc.
Home Medical Equipment & Oxygen Therapy
4638 E Grant Road
Tucson, AZ 85712
Phone 520.296.5925 ● Fax 520.777.4951

CPAP/ BI-LEVEL ORDER FORM

Patient Information:

Name:_____ Date:_____

Address:_____City:_____ State:_____

Phone:_____ SS#:_____ DOB:_____

Primary Insurance:_____ ID#:_____

Secondary Insurance:_____ ID#:_____

Diagnosis: ☐Obstructive Sleep Apnea (327.23) ☐Central Sleep Apnea (327.27)
☐Complex Sleep Apnea (327.21) ☐Other:_____

AHI: _____ Length of Need: ☒99 months (Lifetime) unless otherwise noted_____

Type of Therapy:

☐CPAP @_____ cm H_2O ☐FLEX/EPR_____ (1, 2 or 3)

☐CPAP AUTO Range @:_____to_____ cm H_2O ☐FLEX/EPR_____ (1, 2 or 3)

☐Bi-Level IPAP @:_____ cm H_2O EPAP @:_____ cm H_2O ☐FLEX/EPR_____ (1, 2 or 3)

☐Bi-Level AUTO Max IPAP @:_____ cm H_2O Min EPAP @:_____ cm H_2O ☐FLEX/EPR_____ (1, 2 or 3)

Note: Allied Medcor Services only provides devices with compliance downloads and efficacy capabilities.

Bi-Level S/T Settings:	ASV Advanced/VPAP Adapt Settings:	ASV RAD Qualifications: Yes
IPAP:_____ cm H_2O	EPAP/EEP min:_____ cm H_2O	Did the patient fail CPAP? ☐
EPAP:_____ cm H_2O	EPAP/EEP max:_____ cm H_2O	Is the AHI >5? ☐
Rate:_____ BPM	Rate:_____ BPM	Are central apneas >50% of total? ☐
Flex/EPR:_____ (1, 2 or 3)	Flex/EPR:_____ (1, 2 or 3)	Are central apneas/hypopneas ≥5/hour? ☐

Heated Humidification: ☐Yes ☐No

☐Oxygen @_____ LPM ☐Overnight Oximetry_____

Mask: ☐Full Face ☐Nasal_____ Size:_____
☒Mask Substitution Permissible

☐ A4604 Heated. Tubing 1/3 mo.	☐ A7027 Combo Oral/Nasal Mask 1/3 mo.	☐ A7028 Oral Cushion Repl. 2/mo.
☐ A7030 Full Face Mask 1/3 mo.	☐ A7031 Repl. Facemask Interface 1/mo.	☐ A7032 Repl. Nasal Cushion 2/mo.
☐ A7033 Repl. Nasal Pillows 2/mo.	☐ A7034 Nasal Mask 1/3 mo.	☒ A7035 Headgear 1/6 mo.
☐ A7036 Chinstrap 1/6 mo.	☒ A7037 CPAP/Bi-Level Tubing 1/3 mo.	☒ A7038 Disposable Filters 2/mo.
☒ A7039 Non-Disp. Filters 1/6 mo.	☒ A7046 Repl. Water Chamber 1/6 mo.	
☐ A7029 Repl. Nasal Cush. Combo Mask 2/mo.		

M.D./D.O. Signature:_____ Date:_____

M.D./D.O. Printed Name:_____ NPI:_____

Address:_____

Phone:_____ Fax:_____