1800CPAP.COM
We Deliver. You Sleep.

Prescription/ Letter of Medical Need Request

Ordering Physician	
License Number	
Address	
Phone Number	
Fax Number	

Requesting DME Provider	**Ohio Sleep Awareness LLC** **1800CPAP.com**
OH Respiratory License # **OH Provider Tax ID#**	**HMEL 11385** **26-0504270**

Patient Name	
Date of Birth	
Order Number	

Your patient has purchased a prescription required device, mask or supplies from 1800CPAP.com. Before we release this order to your patient we must have a copy of their prescription on file along with pressure settings. Please fill out the information required below and fax to (888)290-6188.

Preferred CPAP Device Manufacturer: ☐ ResMed ☐ Philips Respironics ☐ Fisher & Paykel Healthcare ☐ Patient Preference

Select Therapy Device

- ☐ CPAP [E0601]
- ☐ AutoCPAP (APAP) [E0601]
- ☐ Bi-Level/BiPAP [E0470]
- ☐ BiPAP Auto [E0470]
- ☐ Bi-Level ST/BiPAP ST [E0471]
- ☐ BiPAP AutoSV [E0471]
- ☐ Oxygen Concentrator

CPAP Mode: _____ cm/H2O _____ ramp time _____ EPR or Flex Setting

Auto CPAP (APAP) Mode: _____min cm/H2O to _____ max cm/H2O _____EPR or Flex

BiPAP/BiLevel Mode: _____IPAP cm/H2O _____ EPAP cm/H2O _____EPR or Flex

ASV Mode: _____Min _____Max _____Rate _____Max Pressure _____Max Support

O2 Levels: _____LPM _____Continuous _____Pulse Dose

CPAP Mask/Patient Interface

- ☐ CPAP Mask Patient Preference
- ☐ CPAP Mask Mask Name : _____ Size_____

Supplies/Accessories

- ☐ Heated Humidifier [E0562]
- ☐ All related supplies necessary for proper use of the above described therapy device (i.e. filters, tubing, headgear, etc).

Duration of Use

- ☐ Lifetime (99 months)
- ☐ Limited Duration _____Years _____Months

Physician Signature: _____Date: ___/____/_____NPI: _____

PLEASE FILL IN ALL REQUIRED AREAS AND FAX TO (888)290-6188

1800CPAP.COM
Address: 651 Reading Rd | Mason, OH 45040
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Visit us at www.1800CPAP. com