BOARDMAN•MEDICAL•SUPPLY
B M S
COMPANY, INC.
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SLEEP EQUIPMENT

****Please fax your patient's insurance information, demographics and chart notes with this form.****

Start Date: _____ Acct #:_____

Patient Name: _____ DOB:_____

Patient Phone #: _____ Ordered By: _____

Address:_____ Height: _____ Weight: _____

Diagnosis/Diagnosis Code:_____ Duration of Need:_____

SLEEP EQUIPMENT

(Please fax diagnostic & titration sleep report)

❑ CPAP E0601 / Supplies at _____ cm H_2O Sleep study performed? ❑ Yes ❑ No Facility: _____
Date Performed: _____

❑ BiPAP E0470 / Supplies at _____ IPAP _____ EPAP
❑ BiPAP St E0471 _____IPAP _____EPAP _____ back up rate
Humidifier ❑ Heated E0562 ❑ Cool E0561
❑ O_2 bled in at _____ LPM

Supplies for Sleep Equipment:

❑ A4604	1 per 3mo	Tubing w/integrated heating element
❑ A7027	1 per 3mo	Combination oral/nasal mask
❑ A7028	2 per mo	Oral cushion for combination oral/nasal mask, replacement only
❑ A7029	2 pr per mo	Nasal pillow for combination oral/nasal mask, replacement only
❑ A7030	1 per 3mo	Full face mask
❑ A7031	1 per mo	Face mask interface, replacement only
❑ A7032	2 per mo	Cushion for use on nasal mask interface, replacement only
❑ A7033	2 pr per mo	Pillow for use on nasal cannula type interface, replacement pair
❑ A7034	1 per 3mo	Nasal interface (mask or cannula type) with or without headgear
❑ A7035	1 per 6mo	Headgear used with PAP device
❑ A7036	1 per 6mo	Chin strap used w/PAP
❑ A7037	1 per 3mo	Tubing used w/ PAP
❑ A7038	2 per mo	Filter, disposable
❑ A7039	1 per 6mo	Filter, non disposable
❑ A7044	1 per 3mo	Oral interface
❑ A7045	1 per 3mo	Exhalation port, replacement only
❑ A7046	1 per 6mo	Water chamber, replacement

I certify that the medical necessity information above is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE: _____ DATE: _____/_____/_____

Printed Name: _____ Address: _____

Phone: _____ NPI #: _____ City/State/Zip: _____

Revised: 4-26-16