

Safety First Sleep Solutions

300 N. State Street - Suite 100
Girard, OH 44420



Sleep Apnea Testing, Equipment & Supplies

Phone: (877) 728-9229
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Start Date: _____ Acct #: _____

Patient Name: _____

DOB: _____

Patient Phone #: _____

Ordered By: _____

Address: _____

Height: _____ Weight: _____

Diagnosis/Diagnosis Code: _____

Duration of Need: _____

HOME SLEEP TESTING

Home Sleep Testing

SLEEP EQUIPMENT

(Please fax diagnostic & titration sleep report)

Auto PAP / Supplies at _____ cm H₂O

CPAP / Supplies at _____ cm H₂O

Sleep study performed? Yes No Facility: _____

Date Performed: _____

BiPAP / Supplies at _____ IPAP _____ EPAP

Supplies for Sleep Equipment:

Back up rate (BiPAP ST)

Humidifier Heated Cool

Chinstrap

Mask

Headgear

Cushion

Pillows

Tubing

Chinstrap

Filters Disposable/Reusable

O₂ 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: _____