FORT Advantage Care
RESPIRATORY AND MEDICAL EQUIPMENT

PAP Device

Written Order Prior to Delivery (WOPD)

Fort Medical Equipment, LLC
306 Washington Street
Fort Atkinson, WI. 53538
Phone: 920-568-9860
Fax: 872-469-1691

Order Date: _____

Patient Name: _____ **Home Phone:** _____

Date of Birth: _____ **Cell Phone:** _____

Diagnosis:
☐ G47.33 Obstructive Sleep Apnea
☐ G47.31 Central Sleep Apnea
☐ G47.39 Other sleep apnea
☐ G47.37 Central sleep apnea in conditions classified elsewhere
☐ Other: _____

Duration:
☐ Lifetime (99)
Other _____

PAP Device (select one and indicate settings)

Cpap (E0601) ☐ _____ **cwp** ☐ **EPR / CFlex** _____

Auto Cpap (E0601) ☐ _____**to**_____ **cwp**

If a Bilevel is being ordered, has the cpap been tried and proven ineffective based on a therapeutic trial? Yes No (please circle)

Bilevel (E0470) ☐ **IPAP** _____ **cwp, EPAP** _____ **cwp**

Bilevel Auto (E0470) ☐ **IPAP max.** _____ **cwp, EPAP min.** _____ **cwp. PS**_____

Bilevel ST (E0471) ☐ **IPAP** _____ **cwp, EPAP** _____ **cwp, Breathing Rate of** _____ **/minute.**

Resmed VPAP Adapt (E0471) ☐ **EEP**_____**CWP PS min** _____ **PS max**_____

Resmed VPAP Adapt Auto (E0471) ☐ **EEP min** _____ **max** _____ **PS min** _____ **PS max**_____

Respironics Bipap Auto SV (E0471) ☐ **IPAP (range 4-25)** _____ **EPAP (range 4-25)** _____ **PS min** _____ **PS max** _____
Backup Rate Set _____ **or Auto** _____

Accessories

HUMIDIFIER (select one)
☐ **Heated (E0562)**
☐ **Cool (E0561)**

TUBING (select one)
☐ **Heated (A4604) 1/3 months**
☐ **Standard (A7037) 1/6 months**

FILTERS (select all that are required)
☐ **Disposable - (A7038) 2/month**
☐ **Non-Disposable (A7039) 1 /6 months**

☐ **Repl Water Chamber for Humidifier (A7046) 1/6 months**
☐ **Chin Strap (A7036) 1/6 months**
☐ **Compliance Monitoring (A9279)**

Mask Options - Select Full, Nasal, Nasal Pillows OR Customer Choice for Mask

☐ **Allow Customer to Select Mask of Choice** (a detailed written order will be sent to you after setup is completed.)

Full Face Mask (check all if the full face mask is selected)
☐ **Mask (A7030) 1/3 months**
☐ **Repl Cushion (A7031) 1/month**
☐ **Headgear (A7035) 1/6 months**

Nasal Mask (check all if a nasal mask is selected)
☐ **Mask (A7034) 1/3 months**
☐ **Repl Cushion (A7032) 1/month**
☐ **Headgear (A7035) 1/6 months**

Nasal Pillow (check all if a nasal pillow system is selected)
☐ **Mask (A7034) 1/3 months**
☐ **Repl Pillows (A7033) 1 set/month**
☐ **Headgear (A7035) 1/6 months**

If the patient is currently receiving oxygen therapy, please complete: Nocturnal Oxygen Bleed In _____**LPM**

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form 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.