Memorial Hermann Home Health PAP Referral Form
Phone: 281-784-7550 • Fax: 281-784-7545

Patient Name: _____ **DOB:** _____ **Order Date:** _____

Diagnosis: ☐ OSA G47.33 ☐ COPD J44.9 ☐ Hypoventilation Syndrome G47.34 ☐ CSA G47.31
☐ Restrictive Thoracic Disorder: Specify/Other: _____

********Please provide F2F and/or any other supporting documentation related to diagnosis********

☐ **CPAP** with heated humidification at _____ cmH2o

☐ **Auto PAP** with heated humidification Range_____ to _____ cmH2o

☐ **Bi-Level** with heated humidification at IPAP _____ EPAP_____cmH2o

☐ **Bi-Level Auto** with heated humidification at IPAP _____ EPAP_____PSmin_____PSmax_____cmH2o

☐ **BI-level S/T** with heated humidification at IPAP ___ EPAP ___CMH2O Rate:___

☐ **Auto Servo Ventilator (ASV)** with heated humidification
Maximum pressure _____ EPAP max_____ EPAP min_____PS max _____PS min _____
CMH2O BIFLEX _____ ☐ Auto Rate or specify a rate_____ BPM

☐ **Average Volume Assured Pressure Support (AVAPS)** with heated humidification
EPAP_____ IPAP max _____CMH2O IPAP min _____CMH2O Tidal Volume_____ ml Rate _____
BPM I- Time_____ sec Rise time_____

PAP supplies to include the following:

4 ea. Combination Oral/Nasal Mask (A7027) 1 per 3 months
24 ea. Mask Pillows for Combo Mask (A7029) 2 per 1 month
12 ea. Mask Full Face Cushion (A7031) 1 per 1 month
24 ea. Mask Pillows (A7033) 2 per 1 month
2 ea. Headgear (A7035) 1 per 6 months
4 ea. Tubing (A7037) 1 per 3 months
2 ea. Filters–Non-disposable (A7039) 1 per 6 months
24 ea. Mask Cushion (A7032) 2 per 1 month
4 ea. Full Face Mask (A7030) 1 per 3 months
24 ea. Mask Cushion (A7032) 2 per 1 month
4 ea. Nasal Interface (A7034) 1 per 3 months
2 ea. Chinstrap (A7036) 1 per 6 months
24 ea. Filters–Disposable (A7038) 2 per 1 month
2 ea. Humidifier Chamber (A7046) 1 per 6 months
4 ea. Heated tubing (A4604) 1 per 3 months

*******Supplies dispensed as needed*******

Length of Need: 12 months

Comments: _____

Oxygen at _____ LPM via ☐ Nasal Cannula ☐ Bleed into PAP ☐ Other _____

☐ Continuous ☐ Nocturnal

****Physician NPI #:** _____ ******

Notice of Medial Necessity: This patient was diagnosed as indicated. Because of the potentially dangerous consequences of disturbed sleep and sleep deprivation, which includes the possibility of falling asleep in critical situations, treatment of this condition is considered mandatory rather than elective, on a nightly basis for life-time duration (estimated period of medical necessity for this equipment is 12 months).

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

Provider Signature	Print Name	NPI/MHHS ID.	Date	Time ☐ AM ☐ PM	Contact No.

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