



10481 164th Place
Orland Park, IL 60467
1-888-598-8515 Phone
1-708-364-0166 Fax

Physician Consent Form for Durable Medical Equipment/CPAP Supplies

Physician: Your patient is requesting CPAP supplies for their sleep apnea therapy. Please authorize CPAP Wholesale to dispense these items by completing the following consent/authorization form.

Date: _____ New Patient: Yes No Replacement equipment only

Patient: _____ DOB: __/__/__

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

CPAP Heated/Humidifier Patient's Preferred Machine Supplies (mask/tubing/filters, etc.)

Pressure Setting: _____ cm

APAP Heated/Humidifier Patient's Preferred Machine

Pressure Setting: _____ minimum cm _____ maximum cm

BIPAP Heated/Humidifier Patient's Preferred Machine

Pressure Setting: _____ IPAP _____ EPAP

Nasal mask Full Face Nasal Pillows Patient's Preferred Mask

Diagnosis of Patient: 327.23 (OSA) 327.2 (Other Unspecified) 327.27 (CSA) 780.53 Hypersomnia w/sleep apnea

Length of Time Needed: 1-99 months (99=Lifetime) _____/months

Name of Ordering Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ NPI#: _____

Physician's Signature: _____ Date: _____