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Physician Consent Form for Durable Medical Equipment/CPAP Supplies

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

PATIENT INFORMATION

Date: ______________________ New Patient: Yes☐ No☐ Replacement Equipment☐

Patient Name: ________________________________ DOB:

Address:______________________________ City: ____________ State: Zip: _____

Home Phone:________________________ Cell Phone: ________________________

EQUIPMENT INFORMATION

☐ CPAP ☐Heated/Humidifier ☐Patient's Preferred Machine ☐Supplies (mask/tubes/filters,)

Pressure Setting: ________________________

☐ CPAP ☐Heated/Humidifier ☐Patient's Preferred Machine

Pressure Setting: ________________minimum cm. _____________ maximum cm.

☐APAP ☐Heated/Humidifier ☐Patient's Preferred Machine

Pressure Setting: ______________IPAP. ________________ EPAP

☐ Nasal Mask ☐Full Face Mask ☐Nasal Pillows ☐Patient's Preferred Mask

Patient Diagnosis Code:_______________Length of Time Needed: ________/Months

ORDERING PHYSICIAN

Name of Ordering Physician:___________________________________

Address:________________________ City:_______________ State: Zip:

Phone: _______________ Fax: _______________NPI #:_______________

Physician's Signature: ____________________ Date:_______________