



REQUEST FOR CPAP / BIPAP / VPAP SUPPLIES

Patient Name: _____ D.O.B _____

Diagnosis: _____ Airway Device: _____

Dear Doctor _____ Date: _____

Metro-Med is being requested to provide your patient with Airway Supplies:

- E0601 CPAP
- E0470 BiLevel
- E0471 VPAP
- E0562 Heated Humidifier
- A7030 Full Face Mask
- A7031 Full Face Mask interface-Replacement
- A7032 Nasal Application Device Replacement Cushion
- A7033 Nasal Pillow Interface
- A7034 Nasal Application Device
- A7035 Headgear
- A7036 Chinstrap
- A7037 6' Tubing
- A7038 Disposal Filter
- A7039 Non-Disposable Filter
- A7046 Humidifier Chamber-Replacement
- A4604 Tubing w/ Integrated Heated

Physician Name: _____ Phone: _____

Address: _____ State License: _____

City, State, Zip: _____ UPIN: _____

Physician's Signature: _____ Date: _____ NPI # _____

