



SimplyAir™ Foam Free Bi-Level

Prescription Form

Patient Information:

Patient Name: _____ Gender: M/F DOB: _____

Address: _____

Phone Number: _____ Alternate Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Diagnosis:

- COPD (J44.9) Obesity Hypoventilation Syndrome (E66.2) OSA (G47.33)
- Central Sleep Apnea (G47.37) Complex Sleep Apnea (G47.31)
- Neuromuscular Dx (multiple codes, please specify): _____

Equipment: SimplyAir™ – Do not Substitute

O2 Bleed in – (If applicable and through mask) _____

- Bi-Level S: IPAP _____ EPAP _____
- Bi-Level SAuto: Max IPAP _____ Min EPAP _____ PS _____
- Bi-Level S/T: IPAP _____ EPAP _____ RR _____
- w/iVOPS: Max IPAP _____ Min IPAP _____ Vt _____

Supplies (*provided by DME company, not available from Movair):

Heated Humidifier (E0562) Heated Tubing (A4604) Standard Tubing (A7037)*

- A7027 COMBINATION ORONASAL MASK; 1 EVERY 3 MONTHS*
- A7028 ORAL CUSHION FOR COMBINATION ORONASAL; 2 EVERY MONTHS*
- A7030 FULL FACE MASK; 1 EVERY 3 MONTHS*
- A7031 FACE MASK INTERFACE, REPLACEMENT; 1 EVERY MONTH*
- A7032 CUSHION FOR USE ON NASAL MASK INTERFACE; 2 EVERY MONTHS*
- A7033 PILLOW FOR USE ON NASAL CANNULA TYPE; 2 EVERY MONTHS*
- A7034 NASAL INTERFACE (MASK OR CANNULA TYPE); 1 EVERY 3 MONTHS*
- A7036 HEADGEAR USED WITH PAP DEVICE; 1 EVERY 3 MONTHS*
- A7036 CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE; 1 EVERY 6 MONTHS*
- A7038 FILTER, DISPOSABLE NASAL INTERFACE (MASK OR CANNULA TYPE); 1 EVERY 3 MONTHS*
- A7039 FILTER, NON-DISPOSABLE, USED WITH PAP; 1 EVERY 6 MONTHS*
- A7046 WATER CHAMBER FOR HUMIDIFIER USED WITH PAP; 1 EVERY 6 MONTHS

Physician Name: _____

Physician Signature: _____

NPI: _____

Date: _____