



I'M NEW TO CPAP - LET'S GET STARTED!

Mahalo for choosing Gammie Homecare as your CPAP supplier. Please use the following checklist below to guide you through the steps to obtain a CPAP/Bipap unit through your insurance. This process applies to customers who have never been on sleep therapy before.

1

Most recent sleep study report

2

Face to face evaluation with your doctor, prior to the original sleep study

3

A new prescription for the CPAP unit with pressure settings , heated humidification and supplies (see attached prescription form)

4

Current face to face chart notes from your doctor

Notes must include the following:

- **That you have a diagnosis of Obstructive Sleep Apnea (OSA)**
- **That you are recommended to start CPAP / Bipap therapy**

****We will send in a payment determination or insurance authorization request if required**

If you have any questions about this process, please feel free to contact Gammie Homecare at (808)877-4032.

Mahalo,

Customer Service Representative

Fax (808) 442-0409

Home Medical Equipment Prescription

Order Date: _____

Patient Name: _____

Date of Birth: _____

Length of Need: 99 Months (Lifetime) Other: _____ months

Equipment Ordered:

CPAP Unit

Fixed pressure set at _____ cmsH2O

Auto CPAP Unit

Pressure set at Minimum _____ cmsH2O, Max _____ cms H2O

Bilevel Unit

EPAP: _____ cms H2O IPAP: _____ cms H2O

Auto Bilevel Unit

Minimum EPAP: _____ cms H2O Max IPAP: _____ cms H2O

Pressure Support: _____

Temperature Controlled Humidification

Supplies Ordered:

A7030 PAP Mask Full Face 1 per 3 months

A7036 PAP Chin Strap 1 per 6 months

A7031 PAP Cushion Full Face 1 per month

A7037 PAP Hose 1 per 3 months

A7032 PAP Nasal Cushion 2 per month

A7038 PAP Disposable Filter 2 per month

A7033 PAP Nasal Pillow 2 per month

A7039 PAP Reusable Filter 1 per 6 months

A7034 PAP Nasal Mask 1 per 3 months

A7046 PAP Humid Chamber 1 per 6 months

A7035 PAP Headgear 1 per 6 months

A4604 PAP Heated Hose 1 per 3 months

Ordering Provider: _____

Address: _____

Ordering Provider Signature: _____