Print Form Reset Form

MyMedSupplies

When completed, please fax to 866.498.9635

PAP/RAD Resupply Prescription

Provider Name:		Patient Name:	
Phone:		Date of Birth:	
NPI:		Date of face to face visit:	
		Length of Need (in months):	

Diagnosis and ICD-10 code

- ☐ G47.31 Primary Central Sleep Apnea
- ☐ G47.33 OSA (adult) (pediatric)
- ☐ G47.37 Central Sleep Apnea in conditions classified elsewhere

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Mask Type must be selected for Medicare recipients (cannot indicate patient preference):

- ○ Full face mask w/ headgear every 3 months, with 1 FF cushion every month
- ○ Nasal mask w/ headgear every 3 months, with 2 nasal cushions or pillows per month

Every 6 months: 1 chin strap, 1 water chamber, 1 non disposable filter
Every 3 months: 1 heated tubing OR non-heated tubing
Every month: 2 disposable filters

Prescriber Signature _____ Date_____