



FAX To: 330-963-6172
 866-669-2710
www.edgepark.com
 1810 Summit Commerce Park
 Twinsburg, OH 44087



Physician's Written Order

Patient	
Patient Name:	Patient DOB:
Address:	Day Phone #:
City: State: Zip:	Evening Phone#:

Insurance	Doctor (Section A)
Primary Insurance:	Physician Name:
Policy/ID #:	Street Address:
Phone #:	City/State/Zip:
Secondary Insurance:	Phone #:
Policy/ID #:	UPIN #:
Phone #:	NPI #:

Diagnosis (Section B)	
<input type="checkbox"/> 327.23 Obstructive Sleep Apnea <input type="checkbox"/> Other:	
Duration of need is lifetime unless otherwise indicated <input type="checkbox"/> Other: Months	
Answer Questions 1-2 (Check Y for Yes, N for No, and D for Does not Apply unless otherwise noted.)	
1. Does the patient have obstructive sleep apnea?	Answers <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D
2. What is the patient's Apnea-Hypopnea Index (AHI)?	
3. Did the patient refuse, reject or discontinue use of CPAP? <input type="checkbox"/> Refuse <input type="checkbox"/> Reject <input type="checkbox"/> Tried but discontinued	
Name of person answering Section B questions, if other than physician (please print):	
Name:	Title: Employer:

Products (Section C)
Provent Sleep Apnea Therapy (Nasal Device)
Please Select Those That Apply:
<input type="checkbox"/> Please provide 90 units/90 night supply, and if applicable 10 night trial pack
<input type="checkbox"/> Other:

I certify that I am the treating physician identified in Section A of this form. I have reviewed Sections A, B and C of the Physician Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed in Section C, and Physician notes and other supporting documentation will be provided to Edgepark upon request. I understand that falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this will be retained as part of the patient's medical record.

Physician signature: (stamps are not acceptable)	Date:
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