Kesling Home Health Care

1115 W. Market St. Logansport, IN 46947
Provider ID#:1135220001 NPI:1568642056 TID:351994022
Phone: 574-735-0082 Fax: 574-753-3910

Name:_____ DOB: _____ Phone: _____

Address:_____

ICD10 Code (*Please Select*): **G47.33 OSA G47.31 CSA J44.9 COPD J43.2 Emphysema Other:**_____
1 Year; Replace Supplies as Medically Necessary – Please Dispense 90 Day Supplies as Allowed

E0601 **Auto CPAP/CPAP**_____CMH2O E0562 (Severe Nasal Dryness) **Heated Humidity** _____

E0470 **Auto BPAP/BPAP** _____CMH2O

E0471 **BPAP ASV**_____CMH2O

*If Oxygen needed with PAP please specify below

E1390 **Oxygen through PAP** ____L

K0738 **Portability by Homefill / Nasal Cannula**____L

E1392 **Oxygen by Portable Oxygen Concentrator**/Nasal Cannula *(limited availability/private pay)* _____L

*Only ONE type of mask and tubing may be ordered at a time by new insurance guidelines

_____ **Full Face Mask** (A7030 - 1 per 3 months) With **Headgear** (A7035 - 1 per 6 months) and **Full Face Cushions** (A7031 - 1 per month)

_____ **Nasal Mask** (A7034 - 1 per 3 months) With **Headgear** (A7035 - 1 per 6 months) and **Nasal Cushions** (A7032 - 2 per month) or **Nasal Pillow Cushions** (A7033 - 2 per month)

_____ **Tubing** (A7037 – 1 per 3 months) __X__ **Chin Strap** (A7036 – 1 per 6 months)

_____ **Heated Tubing** (A4604 – 1 per 3 months) __X__ **Water Chamber** (A7046 – 1 per 6 months)

__X__ **Disposable Filter** (A7038 – 2 per month) __X__ **Non-Disposable Filter** (A7039 – 1 per 6 months)

I, the undersigned, certify that the above prescribed equipment and or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and or supplies prescribed are both reasonable and medically necessary for the accepted standards of medical practice and treatment of this patient's condition. Neither the equipment or supplies are being prescribed as "convenience" equipment. It is important for this patient to have clean and well fitting supplies for treatment of their condition.

X_____ X_____
Physician/Provider Signature Date

Name: _____ NPI:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)-_____-_____ Fax: (_____)-_____-_____ Revised 8/2020