

**ABSOLUTE  
MEDICAL  
EQUIPMENT, INC.**

**CPAP/BiPAP and Accessory Order Form**

Date of Order: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> CPAP E0601 _____ setting  | _____ <b>diagnosis code</b>                  |
| <input type="checkbox"/> Modem   |  |
| <input type="checkbox"/> BiPAP E0470 _____ setting   | _____ <b>length of need</b><br>99 = lifetime |
| <input type="checkbox"/> Humidifier cool E0561 heated E0562 (please circle)                          |  |
| <input type="checkbox"/> Mask, Full Face A7030 _____ specify type _____ size (refill 1 per 3 months) |  |
| <input type="checkbox"/> Mask, Nasal A7034 _____ specify type _____ size (refill 1 per 3 months)     |  |
| <input type="checkbox"/> Tubing A7037 (refill 1 per 3 months)  |  |
| <input type="checkbox"/> Chinstrap A7036 (refill 1 per 6 months)                                     |  |
| <input type="checkbox"/> Headgear A7035 (refill 1 per 6 months)                                      |  |
| <input type="checkbox"/> Filters/Disposable A7038 (refill 2 per 1 month)                             |  |
| <input type="checkbox"/> Filters/Reusable A7039 (refill 1 per 6 months)                              |  |
| <input type="checkbox"/> Humidifier Chamber A7046 (refill 1 per 6 months)                            |  |

Change current setting to \_\_\_\_\_

**Notes:** \_\_\_\_\_

Physicians Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ NPI: \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_

*Physician Signature*

**560 Marksmen Court  
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Newnan, Georgia 30263  
678-854-9234  
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