DME Encounter Form

Patient's name:________________________________ Billing Type: ______________

PT ID:______________ Billing Notes:________________________________

DOB: ______________ ☐ Purchase or ☐ Rental — Months:________

Service Type

☐ New CPAP Set-up
☐ New Supplies
☐ New Bi-Level Set-up
☐ Warranty Exchange
☐ Mask Exchange
☐ Return Equipment
☐ Other ______________

Supplying location

☐ Henderson

Convenience location

☐ Charleston

Date of Service: ______________ Appointment time:______________

DME technician: ______________________ Signature:______________________

Appointment notes:____

CPAP / Bi-Level codes

☐ E0601 CPAP Machine
☐ E0470 Bi-Level Machine
☐ E0471 Bi-Level w/rate
☐ A7027 Oral/Nasal Mask
☐ A7030 Full Face Mask
☐ A7034 CPAP Nasal Mask
☐ E0562 Heated Humidifier
☐ A7046 Humidifier Chamber

CPAP accessories

☐ A7037 6' Tubing
☐ A4604 Heated Circuit Tubing
☐ A7038 Disposable Filter
☐ A7039 Permanent Filter
☐ A7028 Oral/Nasal Mask Cushion
☐ A7031 FFM Cushion
☐ A7032 Nasal Mask Cushion
☐ A7033 Nasal Pillows
☐ A7035 Headgear
☐ A7036 Chinstrap
☐ Other:______________

Device MFG: ______________________ Mask Type: ______________________

Model:______________________ Mask Size: ______________________

Machine SN#: ______________________ Humidifier SN#______________________

Patient Payment Agreement

Deductible Remaining: ______________ Estimated Cost: ______________

Time of Service Payment Amount:______________ Payment Type: ______________

Payment Arrangements: ____

Patient Signature: ________________________________ Date:______________

NOCTURNA Sleep Therapy

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