

# DME Encounter Form

Patient's name: \_\_\_\_\_ Billing Type: \_\_\_\_\_

PT ID: \_\_\_\_\_ Billing Notes: \_\_\_\_\_

DOB: \_\_\_\_\_  Purchase or  Rental – Months: \_\_\_\_\_

## Service Type

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> New CPAP Set-up | <input type="checkbox"/> New Bi-Level Set-up | <input type="checkbox"/> Mask Exchange    |
| <input type="checkbox"/> New Supplies    | <input type="checkbox"/> Warranty Exchange   | <input type="checkbox"/> Return Equipment |
|  |  | <input type="checkbox"/> Other _____      |

## Supplying location

- Southlake       McKinney       Waco

## Convenience location

- Bedford       Granbury       Plano       Willow Bend

Date of Service: \_\_\_\_\_ Appointment time: \_\_\_\_\_

DME technician: \_\_\_\_\_ Signature: \_\_\_\_\_

Appointment notes: \_\_\_\_\_

## CPAP / Bi-Level codes

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> E0601 CPAP Machine     | <input type="checkbox"/> A7027 Oral/Nasal Mask | <input type="checkbox"/> E0562 Heated Humidifier  |
| <input type="checkbox"/> E0470 Bi-Level Machine | <input type="checkbox"/> A7030 Full Face Mask  | <input type="checkbox"/> A7046 Humidifier Chamber |
| <input type="checkbox"/> E0471 Bi-Level w/rate  | <input type="checkbox"/> A7034 CPAP Nasal Mask |   |

## CPAP accessories

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> A7037 6' Tubing             | <input type="checkbox"/> A7028 Oral/Nasal Mask Cushion | <input type="checkbox"/> A7035 Headgear  |
| <input type="checkbox"/> A4604 Heated Circuit Tubing | <input type="checkbox"/> A7031 FFM Cushion             | <input type="checkbox"/> A7036 Chinstrap |
| <input type="checkbox"/> A7038 Disposable Filter     | <input type="checkbox"/> A7032 Nasal Mask Cushion      | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> A7039 Permanent Filter      | <input type="checkbox"/> A7033 Nasal Pillows           |  |

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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McKinney, TX 75070  
972-390-2713

7106 New Sanger Ave.  
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254-741-1377