Fax: 713-955-4372
Phone: 866-764-2165
Email: support@hirohealth.com

HIROHEALTH.COM

Hiro Health
8584 Katy Fwy, Suite 422
Houston, TX 77024

Physician Order

PATIENT INFORMATION		
Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Street Address:		
Phone:	Email:	

DIAGNOSIS		
☑ Obstructive Sleep Apnea (ICD-10: G47.33)	☐ Central Sleep Apnea (ICD-10: G47.31)	☐ Other:

CHOOSE PAP TYPE	*Length of Need: 99*
☑ CPAP or Auto-PAP (E0601) ☐ BiLevel or BiLevel Auto (E0470) ☐ BiLevel w/ Backup Rate or ASV (E0471)	*Pressure Settings (if E0601, 4-20cmH2O will be used if blank):*
CHOOSE HUMIDIFIER: ☑ Heated Humidifier (E0562)	

MASK & PAP SUPPLIES ☑	*Requested Mask Type, Model and/or Size:*	
Nasal Mask (A7034) - 1 every 3 months Nasal Cushion (A7032) - 2 per month OR Nasal Pillows (A7033) - 2 per month Headgear (A7035) - 1 every 6 months	Full Face Mask (A7030) - 1 every 3 months Full Face Cushion (A7031) - 1 per month Headgear (A7035) - 1 every 6 months	Combo Mask (A7027) - 1 every 3 months Combo Cushion (A7028) - 2 per month Combo Pillows (A7029) - 2 per month Headgear (A7035) - 1 every 6 months
TUBING: ☑ Heated Tubing (A4604) - 1 every 3 months	☐ Non-Heated Tubing (A7037) - 1 every 3 months	
FILTERS: ☑ Disposable Filter (A7038) - 2 per month	☐ Non-Disposable Filter (A7039) - 1 every 6 months	
OTHER: ☐ Humidifier Chamber (A7046) - 1 every 6 months	☐ Chinstrap (A7036) - 1 every 6 months	

PHYSICIAN INFORMATION		
Physician Name:		NPI:
Physician Address:		
Physician Phone:	Physician Fax:	
PHYSICIAN SIGNATURE:		**DATE:**

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OR

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