



*A Division of
Midwest Sleep & Respiratory Supply
163 3rd St.
Tracy, MN 56175
Phone: 507.629.8232
Fax: 507.412.8249*

Physician Authorization Form for Durable Medical Equipment (DME)

Dear Physician:

One of your patients is requesting new/replacement CPAP/BIPAP products to treat their sleep apnea. Please authorize Midwest Sleep and Respiratory Supply/SecondwindCPAP.com to dispense these items by completing the following authorization form. A Nationally Registered Respiratory Therapist on file with the State of Minnesota dispenses all equipment.



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Physician Authorization Form for DME – Patient Information

Patient Information

Patient Name: _____
Patient Date of Birth: ___/___/___
Patient Address: _____
Patient Phone # _____

Equipment Overview

Please check the following that apply and specify pressure requirements:

_____ CPAP Machine & Accessories

Pressure Setting: _____

_____ Automatic CPAP/BIPAP Machine & Accessories

Pressure Range: max ___/min___

_____ BiPAP Machine & Accessories

Insp. Pressure ___ Exhal. Pressure ___

‘Accessories’ include Heated Humidifier, and Nasal Interface.

All pressures indicate cm h20.



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Application for DME – Physician Information (Required)

Physician Name: _____
Physician Address: _____
Physician Office/Clinic Phone # _____
Date of Application: ___ / ___ / ___
Physician License/NPID #: _____
Physician Signature: _____

Notes:
