Date: [Date]

To: [Provider Name/DME Company]
Fax/Email: [Recipient Contact Information]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Study: [Date of Sleep Study]

Subject: Prescription and Titration Orders for Sleep Apnea Therapy

Dear [Recipient Name],

Following the recent post-study evaluation and sleep titration study for the above-named patient, the following clinical settings have been established for their [CPAP/BiPAP/ASV] therapy.

Diagnosis: [Diagnosis, e.g., Obstructive Sleep Apnea (G47.33)]
Device Type: [Specific Device Brand/Model]

Prescribed Settings:

- **Mode:** [Fixed/Auto/Bilevel]
- **Pressure Setting:** [e.g., 10 cmH2O or Range 6-14 cmH2O]
- **Pressure Relief:** [e.g., EPR Level 2 / Flex Setting]
- **Humidification:** [e.g., Heated Humidifier - Auto]
- **Ramp Time:** [e.g., 20 minutes or Off]

Equipment & Supplies:

- **Interface:** [Nasal/Full Face/Pillows] - Patient preference: [Size/Style]
- **Replacement Schedule:** Standard CMS/Insurance replacement schedule for masks, tubing, and filters.

Clinical Justification:
The titration study demonstrated that these settings effectively reduced the patient's Apnea-Hypopnea Index (AHI) to [AHI Result] and maintained oxygen saturation above [O2 Percentage].

Please provide the patient with the necessary equipment and initiate compliance monitoring. Please send a confirmation of setup to our office.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]

[NPI Number]
[Clinic Name]