847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

CPAP or BiPAP Order Form

Referral Source:_____ Referral Source Phone:(_____)_____

Please send the most recent Sleep Study and face to face with order.

PATIENT INFORMATION

Last Name:_____ First Name:_____

Address: _____

City:_____ State: Illinois Zip code:_____

Phone Number: (_____)_____

Sex: Female_____ Male_____ Birth Date:_____/_____/_____

Height:_____ Weight:_____

DIAGNOSIS INFORMATION

Primary :_____

Secondary:_____

INSURANCE INFORMATION

Medicare Number:___ _____

Medicaid Recipient Number:_____

Managed Care Medicaid Name:_____ Policy:_____

Private Insurance Name:_____ Policy:_____

PRODUCT(S) REQUESTED

[ ] CPAP - E0601 [ ] Heated Humidifier

[ ] BiPAP - E0470 [ ] Heated Humidifier

E0601 device is covered for the treatment of obstructive sleep apnea (OSA) if criteria A – C are met:

E0470 device is covered for those beneficiaries with OSA who meet criteria A-C below, in addition to criterion D:

A. The beneficiary has a face-to-face clinical evaluation by the treating practitioner prior to the sleep test to assess the beneficiary for obstructive sleep a

B. The beneficiary has a sleep test (as defined below) that meets either of the following criteria (1 or 2):

1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events
2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
   a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
   b. Hypertension, ischemic heart disease, or history of stroke.

C. The beneficiary and/or their caregiver has received instruction from the supplier of the device in the proper use and care of the equipment

Length of Need_____ (1-99months) 99=lifetime

PHYICIAN INFORMATION

Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone Number:(_____)_____

NPI:_____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:_____ Date:_____/_____/_____

apnea.

; or,