Integrated 2000 Bloomingdale Road, Ste 205 Glendale Heights, IL 60139 (630) 582.0202 Fax: (630) 582.3787

# Certificate of Medical Necessity – CPAP/BIPAP Rx

## PATIENT INFORMATION

| | |
|---|---|
| Patient Name | Date of Birth |
| Social Security # | Emergency Contact/Phone # |
| Address | City/State/Zip Code |
| Home Phone # | Alternate Phone # |

## INSURANCE INFORMATION

| | |
|---|---|
| Name of Insurance Company | Insurance Company Phone # |
| Insured Name | Insured Date of Birth |
| Group # | I.D. # |

**Please Check Box of Equipment Needed**

*** Duration of Equipment: LIFETIME –OR-** _____

**Diagnosis:** **327.21** **327.23** **780.53** **Obstructive Sleep Apnea** **Other:** _____

☐ **CPAP** (E0601) (attach current sleep study) Setting @ _____ CWP with mask (A7034), tubing (A7037), and headgear (A7035)

- ☐ C-Flex with a comfort setting @ 2 or: _____
- ☐ Machine or Mask Special Preference: _____

☐ **Auto PAP** (E0601) (attach current sleep study) Setting @ _____ to _____ CWP with mask (A7034), tubing (A7037), and headgear (A7035)

- ☐ Machine or Mask Special Preference: _____

☐ **BIPAP** (E0470) ☐ **BIPAP ST** (E0471) (attach current sleep study) mask (A7034), tubing (A7037), and headgear (A7035) Settings @ _____ IPAP and _____ EPAP if ST B/R: _____

- ☐ Machine or Mask Special Preference: _____

☐ **Humidifier** ☐ Heated (E0562) ☐ Cool (E5061)

☐ **Download:** ☐ 1& 6 Months or ☐ _____

The above patient has been diagnosed by polysomnography with Obstructive Sleep Apnea (OSA), a condition in the muscle that controls the tongue and soft palate to relax too much during sleep and obstruct the upper airway, preventing breathing. Management of OSA involves the use of a Continuous Positive Airway Pressure (CPAP) or BI-LEVEL Device. CPAP/BIPAP therapy is considered the best available and most cost effective therapy for OSA. It provides an alternative to tracheotomy, or to the less radical uvulopalatopharynogoplasty surgery, for this patient whose disease if left untreated is potentially life threatening.

☐ **Oxygen @** _____ **LPM Nocturnal via CPAP/BIPAP**
Concentrator (E1390)

☐ **Other:** _____

**Physician:** _____ **Lic#** _____ **UPIN #** _____

**Address:** _____ **Phone:** _____ **Fax:** _____

_____

**Contact Name:** _____

**Physician Signature:** _____ **Date:** _____