Integrated Respiratory Solutions

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Certificate of Medical Necessity – CPAP/BIPAP Rx

PATIENT INFORMATION

Patient Name	Date of Birth
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 ICD-10: ☐ **G47.33 (Obstructive Sleep Apnea)** ☐ **G47.31 (Central Sleep Apnea)** ☐ **Other:**_____

☐ **CPAP** (E0601) Setting @ _____ CWP with ☐ C-Flex with a comfort setting @ 2 or: _____

☐ **Auto PAP** (E0601) Setting @ _____ to _____ CWP

☐ **BIPAP** (E0470) ☐ **BIPAP ST** (E0471)
Settings @ _____ IPAP and _____ EPAP if ST B/R: _____

☐ Machine or Mask Special Preference: _____

☐ **All Related supplies**: mask (A7030/A7034), tubing (A7037/A4604), headgear (A7035), and filters (A7038/A7039)
☐ **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 Printed Name: _____ **NPI#** _____

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

_____

Contact Name: _____

Physician Signature:_____ **Date:** _____