phone 562.900.8446 fax562.420.7350
email thesleepapneagirl@gmail.com

Physician's Prescription & Statement of Medical Necessity

Please fax this form along with a copy of patient's H&P/Progress Note and Insurance Card

First:____________________ Last: ____________________ Sex: ________ DOB: ____________

Address: ____________________________________ Social Security: ____________________

City, ST, Zip: ______________________________ Primary Ins. Co.: ____________________

Home Phone:_________________________________ Primary Ins. ID#: ____________________

Work Phone: ________________________________ Secondary Ins. Co.:__________________

Cell Phone: _________________________________ Secondary Ins. ID#:__________________

Medical Necessity

*Check ALL boxes that apply to patients condition

- ☐ Obstructive Sleep Apnea (G47.33)
- ☐ Central Sleep Apnea (G47.37)
- ☐ Excessive Daytime Sleepiness (G47.30)
- ☐ Periodic Limb Movement (G25.89)
- ☐ Ischemic Heart Disease (I25.9)
- ☐ Hypertension (I10-I15) ☐ COPD (J44.0)
- ☐ Snoring (G47.30) ☐ Cheyne-Stokes (R06.3)

CPAP/BI-Level Equipment

*All machines have SmartCards and/or modems

- ☐ E0601 CPAP Unit __________ cmH20
- ☐ E0601 Auto CPAP _____-_____ cmH20
- ☐ E0470 Bilevel Unit _____/_____ cmH20
- ☐ E0470 Auto Bilevel _____-_____ cmH20
- ☐ E0471 Bilevel S/T BPM(for E0471) : ______ /min | Pressure settings: __________
- ☐ E0471 Bilevel S/V BPM(for E0471) : ______ /min | Pressure settings: __________
- ☐ Other:__________________________

Humidifier

- ☐ E0562 Heated CPAP Humidifier

CPAP/BI-Level Supplies/Other

- ☐ All CPAP Supplies (Non Medicare Patients Only)
- ☐ A7027-A7029 Hybrid Mask/Cushions (Quarterly)
- ☐ A7030 Full Face Mask (Quarterly)
- ☐ A7031 Face Mask Flap (Monthly)
- ☐ A7032 Seals/Cushions/Flaps (Bi-Weekly)
- ☐ A7033 Nasal Pillows (Bi-Weekly)
- ☐ A7034 Nasal Application Device (Quarterly)
- ☐ A7035 Headgear (Semi-Annually)
- ☐ A7036 Chin Strap (Semi-Annually)
- ☐ A7037 Tubing (Quarterly)
- ☐ A4640 Heated Tubing (Quarterly)
- ☐ A7038 Filters - Disposable (Bi-Weekly)
- ☐ A7039 Filters - Non-Disposable (Semi-Annually)
- ☐ A7044 Oral Interface (Quarterly)
- ☐ A7046 Replacement Water Chamber (Semi-Annually)
- ☐ A9279 Device Monitoring
- ☐ 94660 RT Evaluation and PAP Set-up
- ☐ 95807 PAP Acclimation

Non Medicare - Medicare

- ☐ Purchase
- ☐ Length of Need: 99/Lifetime
- ☐ Start Date: _________

Fit for Mask Mask: ____________________________

☐ May Substitute ☐ Do Not Substitute

Statement of Medical Necessity

The above referenced patient has an absolute Medical Necessity for the item(s) listed above. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the standards of medical practice for this patient's condition. The duration of the equipment/supplies will be lifetime unless otherwise indicated here: ______________

Physician Name: ______________________ NPI#: ______________________

Office Phone: ______________________ Address: ______________________

Office Fax: ______________________ ______________________

Physician Signature: ______________________ Date: ______________________