Certificate of Medical Necessity

Detailed Written-Order Prior to Delivery

For PAP

Fax 256-259-1498 or 256-571-9158

Patient Name ________________________________ DOB _____________ Length of Need ____________

Date of face to face clinical exam prior to sleep test _____________________ Start Date of Order _____________

Diagnosis Code G47.33 OSA or G47.37 Central Sleep Apnea

_____ E0601 CPAP Pressure Setting _____ E0470 BiPap ______ E0471 RAD

_____ E0562 Heated Humidifier

_____ E0561 Non Heated Humidifier

_____ A7027 Combination oral/nasal mask (frequency for masks 1 every 3 months)

_____ A7030 Full Face Mask (frequency for masks 1 every 3 months)

_____ A7034 Nasal Interface (mask or cannula type (frequency for masks 1 every 3 months)

_____ A7035 Headgear (frequency for headgear 1 every 6 months)

_____ A7036 Chinstrap (frequency for chinstrap 1 every 6 months)

_____ A7037 Tubing (frequency for tubing 1 every month)

_____ A4604 Heated Tubing w/integrated heating element (frequency for heated tubing 1 every 3 months)

_____ A7038 Filters disposable (frequency for disposable 2 every month)

_____ A7039 Filters non-disposable (frequency for non-disposable filter 1 every 6 months)

_____ A7046 Water chamber for humidifier used with PAP (frequency humidifier 1 every months)

_____ Other ____

Replacement Items to be used in future:

_____ A7028 Oral Cushion for combination oral/nasal mask replacement only (frequency 2 per month)

_____ A7029 Nasal Pillows for combination oral/nasal mask replacement only (frequency 2 per month)

_____ A7031 Full Face mask interface replacement only (frequency 1 per month)

_____ A7032 Cushion for use on nasal mask interface replacement only (frequency 2 per month)

_____ A7033 Pillow for use on nasal cannula type interface replacement only (frequency 2 per month)

If the physician is ordering a BiPAP: CPAP has been tried and proven ineffective based on trial conducted in a facility or home setting and there is documentation in the patients' medical record.

Physician Printed Name: _________________________________ **NPI: _____________________**

Physician Signature: ____________________________________ **Date: ____________________**