FAX: 855-475-5614 PHONE: 833-523-2609

Prior Authorization PAP Device Request Form

Date Requested: **Date of Service:**

☐ Standard Request	☐ Expedited Request I Certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. **Provider Signature:** _____ Date: _____
Patient Name:	Ordering Provider:
Patient Health Insurance ID #	Service Provider:
Patient birthdate:	Contact Name:
ICD 10 Diagnosis:	Contact Phone: Fax:
Height: ____ Feet _____ Inches Weight: _____ Lbs. **Estimated Length of time needed**: _____ ☐ **CPAP** @ ____ cm H_2O ☐ **Auto CPAP**@ _____ Min ____Max cm H_2O ☐ **BiPAP**@ ____I/____E cm H_2O ☐ **BiPAP S/T**@ ____I/____E cm H_2O with ___BPM ☐ **O2 Bleed in** @___LPM ☐ **VPAP Auto** (RESMED)@ ___IPAP Max, ___EPAP Min _____Pressure Support ☐ **BiPAP Auto** (Respironics)@ ___IPAP Max, ___EPEP Min _____PS Max, ____PS Min	☐E0470 BiPAP w/o B/U Rate ☐E0471 BiPAP S/T w/ B/U Rate ☐E0562 Hum Heated ☐E0601 CPAP/Auto CPAP Device ☐A7034 Nasal Pillows ☐A7030 Full Face Mask ☐A7034 Nasal Mask ☐A7036 Chin Strap ☐E0470 PiPAP Auto/VPAP Auto
1. Is the device being ordered for treatment of obstructive Sleep Apnea?	☐**Y** ☐**N**
2. Date of Initial face to face eval	___/___/_____
3. Enter date of sleep test	___/___/_____
4. Was sleep test conducted in facility-based lab?	☐**Y** ☐**N**
5. What is patients AHI or RDI?	_____
6. Does patient have at least one of the following: excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease or history of stroke?	☐**Y** ☐**N**
7. If bilevel device is ordered, has CPAP device been tried and found ineffective?	☐**Y** ☐**N** ☐**NA**
RECERTIFICATION ONLY	
1. Enter date of follow up face to face eval	___/___/_____
2. Is there a report documenting patients used PAP at least 4 hours per night on 70% of nights in 30 consecutive day period?	☐**Y** ☐**N**
3. Did the patient demonstrate improvement in symptoms of OSA with use of PAP?	☐**Y** ☐**N**
Please fax/email completed form along with Supporting Clinical to include Physician Order and Letter of Medical Necessity to 855-475-5614 Please note: Prescription is valid for one year from signature date unless order changes.	

Physician Signature: _____ Date_____