



NEW MEDICARE PATIENT COMPLIANCE PAP PROGRAM (Positive Air Pressure)

Patient Name: _____ DOB: _____

Account Code: _____ Original Set-up date: _____

- Medicare has implemented a new policy regarding Positive Airway Pressure Devices. See attached letter.
- Physician has performed an INITIAL face-to-face visit with the patient and a Sleep Study was performed. Sleep Therapy Solutions has received a copy of the physician’s initial evaluation and the Sleep Study. General information should include sleep history and symptoms which may be caused by OSA, Epworth Sleepiness Scale other validated sleep inventory, or pertinent physical examination (e.g., Body Mass Index, neck circumference, upper airway exam, and cardiopulmonary exam)
- Proper equipment usage and compliance was reviewed with patient.
- Your PAP machine must be downloaded after the first 31 days of treatment to ensure 70% usage of 30 consecutive days at 4 hours per night.
- Your PAP device compliance data must be downloaded by bringing it into our office or mailing the data to our office. If you are mailing your data card, you will be instructed on how to do the procedure, and you may be provided with a self-addressed stamped envelope for your convenience.
- You must have a face-to-face visit with your physician during the second or third month of the PAP trial that documents improvement of your symptoms.
- A data report from the PAP device which documents use of the PAP device for at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.
- Sleep Therapy Solutions must receive a copy of your re-evaluation during the PAP trial and the data report from the PAP device indicating compliance during the trial.
- Failure to comply with the new Medicare guidelines will result in discontinuation of treatment after 90 days.

Treating physician’s contact information

Name: _____ Phone: _____

Due date for the data card to be received by Sleep Therapy Solutions for 30 day download: _____

Physician appointment must be made before 90 day period and completed by: _____

Patient Care Technician’s Signature: _____ Date: _____

Patient Signature: _____ Date: _____