# Medical Prescription and Statement of Medical Necessity

## Patient Demographics

**Patient Name:** **DOB:**

**Address:** **Gender:**

| Patient Insurance | Complete this form & Fax-**up-to-date** patient face sheet | FAX: 855.201.3647 |
|---|---|---|

**Choose Diagnosis (ICD-9 code must be to the highest level of specificity) (check all that apply)**

- 327.23 Obstructive Sleep Apnea
- 327.26 Sleep Related Hypoventilation/Hypoxemia
- 327.27 Central Sleep Apnea
- Other

| PAP Sleep Therapy Prescription | Oral Appliance Prescription |
|---|---|
| _____ Auto-CPAP Therapy (E0601) | ____ Best fit |
| _____ Minimum $CmH_2O$ = 4 change minimum to _____ | |
| _____ Maximum $CmH_2O$ = 20 change minimum to _____ | |

**LETTER OF MEDICAL NECESSITY**

The above referenced patient has a Medical Necessity for the items 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

**In addition to reviewing the Sleep Study the patient has comorbidities marked below, which require the necessary prescribed items above.**

| | |
|---|---|
| Hypertension | Pulmonary hypertension |
| Excessive daytime sleepiness with a Epworth scale of 10 or greater | Impaired cognition or mood disorders |
| Sleepy study findings of AHI | Ischemic heart disease or history of stroke |
| Diabetes | BMI > 28 |
| Witnessed apneas | Habitual snoring |
| Other: (specify) | |

**Please sign and date this form. Fax this form, the sleepy study report, insurance card, demographics, prescription & face sheet to 855.201.3647**

## Physician signature and date