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	780.51 Sleep Apnea (with Insomnia)	
327.26 Sleep Related Hypoventilation/Hypoxemia	780.53 Sleep Apnea (with Hypersomnia)	
327.27 Central Sleep Apnea	780.51 Intrinsic Sleep Disorder NOS (Upper Airway Resistance Syndrome)	
Other	786.09 Primary Snoring	

PAP Sleep Therapy Prescription		
_______ Auto-CPAP Therapy (E0601)	____ Best fit Mask	chin strap
______ Minimum CmH_2O = 4 change minimum to _________	Full Face Mask	Filter
______ Maximum CmH_2O = 20 change minimum to _______	Headgear	ClimateLine Tubing Tubing

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