OFFICE USE ONLY

RECEIVED :_____

SCANNED:_____

CERTIFICATE OF MEDICAL NECESSITY
For CPAP/BiPAP Therapy

Phone (919)477-1588
Toll Free (866)499-1588
PATIENT INFORMATION

This prescription may be filled by the supplier of your choice

Fax: (919)477-1688
Fax: (866)499-1288
CPAP/BIPAP PRESCRIPTION

PATIENT NAME:_____ Date of Birth:_____ ACCT. #:_____

ADDRESS:_____CITY:_____STATE:_____ ZIP:_____

GENDER : ☐ MALE ☐ FEMALE / HOME PHONE:_____ ALTERNATE NUMBER:_____

INSURANCE:_____ POLICY # _____ GROUP # _____

Order Start Date: _____ **E0562: Humidity Heated:** ☐ **Rental:** ☐

E0601: – _____ @ _____ cmH2O Flex (EPR) (optional) _____

E0470: **BiPAP** @ _____ cmH2O BiFlex (Optional) _____

E0470:**BiPAP AUTO** @ Min EPAP _____ Max IPAP _____ Min Pressure Support _____

E0471: **BiPAP ST** @ IPAP: _____ EPAP: _____ Insp. Time: _____ Rate: _____ Flex (EPR) :_____

E0471: – @ Min EPAP _____ Max EPAP _____ Max Press_____ Min PS _____ Max PS _____

☑ **CPAP/BiPAP Supplies (Checked Below)** Rate _____ BiFlex (EPR) _____

Max pressure on ResMed equipment will equal Max EPAP + MAX PS and not exceed 25cmH20

A7030	☐ Full Face Mask Shell	1 per 3 months	A7038	☐ Disposable Filters	2 per month
A7031	☐ Full Face Seal	1 per month	A7039	☐ Non Disposable Filters	1 per 6 months
A7032	☐ Nasal Seal	2 per month	A7046	☐ Water Chamber	1 per 6 months
A7033	☐ Nasal Pillows	2 per month	A4604	☐ Climate Line Tubing	1 per 3 months
A7034	☐ Nasal Shell	1 per 3 months	A7037	☐ Pressure Line Tubing	1 per 3 months
A7035	☐ Headgear	1 per 6 months	A7027	☐ Combo Oral/Nasal Shell	1 per 3 months
A7036	☐ Chinstrap	1 per 6 months	A7028	☐ Hybrid/Oral Cushion	1 per months
A7037	☐ Standard Tubing	1 per 3 months	A7029	☐ Hybrid Pillows	2 per months

☐ Patient has a _____

☐ Adjusted patient settings to:_____

☐ Home Auto Titration Study: _____ @ _____cmH2O; Duration _____

Prognosis: ☐ **Good** ☐ **Fair** ☐ **Poor** **Length of Need:** LIFETIME

Oxygen: ☐ **Yes:** (if <88%) ☐ **No** Lowest O2 Saturation _____% Oxygen at _____ lpm during sleep

Diagnosis: ☐ OSA (G47.33) ☐ COPD (J44.9) ☐ CSA (G47.31) ☐ OTHER(_____)_____

Physician Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I certify that I am the treating physician and I have had a face-to-face evaluation with this patient prior to ordering these devices.

I have completed this Certificate of Medical Necessity form and any statements here have been reviewed and signed by me. I certify that the medical information is true, accurate, and complete to the best of my knowledge. I certify that the above equipment/test ordered are medically necessary in the treatment of this patient.

Physician Signature: _____ Date:_____

Prescription, PSG, and titration study faxed by: _____ Date_____