Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Durable Medical Equipment – CPAP Adult/BiPAP/AUTOCPAP/CPAP Child Precertification Review

Date: _____ Reference #: _____(provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call HealthLink at 1-877-284-0102.

Provider Information

Provider Name: _____

Address: _____

Phone: _____

Fax: _____

Patient Information

Patient Name: _____

ID Number: _____

Patient DOB: _____

Address: _____

Phone: _____

Ordering Physician Information

Ordering Physician Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Treatment Information

Equipment Ordered: _____

DME (HCPC/CPT) Code: _____

Start Date: _____

Anticipated Duration of Service: _____

CPAP Possible Indications (check all that apply)

- ☐ Not Applicable
- ☐ Cardiac Arrhythmias
- ☐ Epworth Sleepiness Scale
- ☐ Excessive Sleepiness such as inappropriate daytime napping or sleepiness that interferes with daily activities
- ☐ H/O Stroke
- ☐ HTN
- ☐ Ischemic Heart Disease
- ☐ Polysomnography determined AHI/RDI _____
- ☐ Pulmonary HTN
- ☐ Other, please specify _____

BiPAP Possible Indications (check all that apply)

- ☐ Not Applicable
- ☐ Claustrophobia
- ☐ Inability to breathe through nose
- ☐ Medical record documentation of CPAP failure *(please attach copy of record)*
- ☐ Pain or discomfort associated with CPAP
- ☐ Patient intolerance
- ☐ Patient requires high pressures of CPAP(> 10 cm H20) complains of pressure discomfort
- ☐ Other, please specify _____

AUTOCPAP Possible Indications (check all that apply)

- ☐ Not Applicable
- ☐ Topical nasal corticosteroids spray or anticholinergic spray was tried to relieve significant nasal complaints
- ☐ Patient is intolerant of high fixed CPAP pressures
- ☐ Nurse or Technician in consultation with attending physician, made changes to the CPAP circuit or mask using different nose masks, face masks, nasal pillows or head harness to achieve maximum comfort
- ☐ The required fixed level CPAP is at least 10 cm H20 by in-laboratory technician attended CPAP titration during polysomnography
- ☐ Other, please specify _____

CPAP for Children Possible Indications (check all that apply)

- ☐ Not Applicable
- ☐ Documented diagnosis of obstructive sleep apnea
- ☐ Polysomnography documented AHI or AI; AND
- ☐ Adenotonsillectomy was unsuccessful in relieving obstructive sleep apnea; OR
- ☐ Adenotonsillar tissue is minimal; OR
- ☐ Adenotonsillectomy is inappropriate as obstructive sleep apnea is attributed to another underlying cause or is contraindicated
- ☐ Other, please specify _____

Additional Comments

_____

_____

_____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____