HME HOME MEDICAL EQUIPMENT LOCATIONS

Please Provide Clinical Information for Documentation

MANDATORY REQUIREMENTS FOR MEDICARE & INSURANCE COMPANIES

Please check and forward the following clinical information and other necessary clinical documents to your medical equipment provider.

- ☐ Physician's 'face-to-face' notes must provide the correct diagnoses necessary prior to Sleep Study or DME equipment.
- ☐ Clinical notes are required for insurance authorization and to avoid insurance denials for Sleep Studies or DME.
- ☐ Please fax sleep study results from other sleep centers.

PATIENT INFORMATION

Name _____ Gender ( ) M ( ) F Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Primary Insurance: _____ Policy # _____

Secondary Insurance: _____ Policy # _____

CERTIFICATE OF MEDICAL NECESSITY – PRESCRIPTION(S) – Sold to Patient

Other Equipment/Diagnosis

Please write in any additional diagnosis and/or medical equipment needed in the space below.

CPAP/BiPAP

( ) CPAP ( ) Bipap ( ) Pressure change
( ) Mask ( ) Tubing ( ) Replacement Supplies
( ) Humidifier ( ) Heated, ( ) Cool

Dx if AHI 15 or >: ___ OSA (G47.33), ___ COPD (J44/1)
___ Central Apnea (G47.31)

If AHI is less than 15, a secondary diagnosis is required:
____ EDS, ____ HTN, ____ Insomnia, ____ h/o CVA

- CPAP @ _____ cm H2O
- BiPAP-S @ I_____, E _____ cm H2O
- BiPAP-ST @ I_____, E _____ cm H2O
- BiPAP-ST @ _____ back-up rate ventilation

Prescriptions for all DME (Oxygen, CPAP/BiPAP) includes all DME and related medical supplies which are sold to the patient as supplied under the prescription CMN (Certificate of Medical Necessity).

Oxygen

Dx: COPD – J44.1 ( ), CHF – I50.9 ( ), Other _____
Home Oxygen: _____ Portable Needed: Yes ( ), No ( )
Room Air 02 Sat: _____ (qualifying < 88%) Date: _____
RA Sat done at: Within 2 days of Hosp D/C ( ), Home ( )
Physician's Office ( ), Other _____
02 treatment @ ____ LPM via nasal cannula, ____ hrs
Continuously _____, with sleep only _____
Estimated Length of Need: _____ 99 = Lifetime, Other _____
Standard Continuous Flow Regulator _____
Conserving Device Regulator _____ (MD ensures sats > 90%)

Print MD Name _____ Group Name _____

Address _____

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 services. 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 test / equipment ordered are medically necessary in the treatment of this patient.

Physician Signature _____ **NPI #** _____ **Date** _____

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