BayView HOMECARE

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CPAP therapy

Patient name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Insurance name: _____

Insurance number: _____

Date seen prior to sleep test: _____

Diagnosis test date: _____

Diagnosis: ☐ OSA: ICD-9 327.23 / ICD-10 G47.33
☐ Primary CSA: ICD-9 327.21 / ICD-10 G47.31 ☐ Other: _____
☐ Nonobstructive alveolar hypoventilation: ICD-9 327.24 / ICD-10 G47.34

Prescription start date: _____

Duration of need: ☐ 99 months ☐ Other: _____

Equipment and provider: _____

Phone: _____ **Fax:** _____

CPAP Therapy	E0601 + E0562 + A9279 + A4604
☐	
	DEFAULTS
☐ Pressure:_____cm H_2O (4–20 cm H_2O)	10
Ramp time:_____min(s) (Auto, OFF–45 min.)	
EPR™: ☐ 1 ☐ 2 ☐ 3	

Notes

Mask Interface	HCPCS	Qty/Freq
Full Face Masks	**A7030**	**1 per 3 months***
☐ F20 – AirFit™ or AirTouch™	☐ F20 for Her – AirFit™ or AirTouch™	
☐ AirFit™ F20	☐ AirFit™ F20 for Her	
☐ AirTouch™ F20	☐ AirTouch™ F20 for Her	
☐	☐	
☐ Other masks available	☐	
☐	☐ Other _____	
Nasal Masks	**A7034**	**1 per 3 months***
☐ AirFit™ N20	☐ AirFit™ N20 for Her	
☐	☐	
☐	☐	
☐ Other _____		
Nasal Pillows Masks	**A7034**	**1 per 3 months***
☐ AirFit™ P10	☐ AirFit™ P10 for Her	
☐	☐	
☐ Other _____		

Therapy Accessories	HCPCS	Qty/Freq
☒ Wireless monitoring	A9279	
☐ ClimateLineAir™ heated tubing	A4604	1 per 3 months*
☐ ClimateLineAir™ Oxy heated tubing	A4604	1 per 3 months*
☐ SlimLine™ tubing	A7037	1 per 3 months*
☐ Standard tubing	A7037	1 per 3 months*
☐ Humidifier tub, disposable	A7046	1 per 6 months*
☐ Humidifier tub, cleanable	A7046	1 per 6 months*
☐ Filter, disposable	A7038	2 per month*
☐ Nasal cushions	A7032	2 per month*
☐ Pillow cushions	A7033	2 per month*
☐ Full face cushions	A7031	1 per month*
☐ Headgear	A7035	1 per 6 months*
☐ Chin strap	A7036	1 per 6 months*

Attach

1) Copy of sleep test.

2) Copy of medical record from initial face-to-face prior to sleep test.

Medicare and commercial payors will not authorize service without supporting documentation.

DO NOT SUBSTITUTE

Statement of medical necessity: The above patient has undergone diagnostic evaluation. This evaluation has confirmed a positive diagnosis of sleep apnea. Positive airway pressure therapy is medically necessary and provides effective treatment of this disorder.

NPI#: _____ **Physician name:** _____

_____ _____

Physician signature *Signature date*

*As required, consistent with insurer replacement requirements.

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