

Non-invasive Airway Assistance Devices—Prior Authorization Form (CPAP, BIPAP, AutoPAP)

BENEFICIARY INFORMATION

Name: _____ Diagnosis: _____ Diagnosis Code: _____

Medicaid ID #: _____ DOB: _____

REQUESTING PROVIDER INFORMATION

Name: _____ Medicaid Provider #: _____

Date of Request: _____ Phone#: _____ Fax#: _____

Provider Signature: _____ Office Contact: _____

SUPPLYING VENDOR INFORMATION

Company Name: _____ Medicaid Provider #: _____ Fax #: _____

Phone #: _____ Contact: _____

TYPE OF REQUEST: CPAP Bi-PAP AutoPAP HCPCS code: _____

Initial appointment with Sleep MD: _____ Polysomnogram date: _____

AHI: _____ Oxygen saturation: minimum _____ maximum _____

PAP titration study date: _____ Titrated using: CPAP BI-PAP AutoPAP

Follow up appt with Sleep MD date: _____ Initiation of PAP therapy date: _____

Number of nights used for four (4) or more hours in a consecutive 90 day time period?
Month 1 _____ Month 2 _____ Month 3 _____

Coverage requested beyond initial three (3) month trial Requested rental length: _____

Reason for continued rental: _____

Cause for replacement _____ Date equipment initially received: _____

Note: For equipment older than 5 years, a face to face evaluation by a Sleep Medicine or Pulmonary Specialist treating MD is required, documenting that the beneficiary continues to use and benefit from the PAP device.

Conversion If yes, check appropriate box CPAP to Bi-PAP Bi-PAP to CPAP Other _____

What is the reason for conversion? _____

Note: To be considered for continued use, adherence to therapy is defined as use greater than or equal to four (4) hours per night for a minimum of 21 nights (70% of nights) during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. No prior authorization is required for the first three (3) month rental. All PAP therapy following this three month time period must be prior authorized and should be submitted on this form.