Confirmation of Medical Order for Sleep Apnea Treatment

Name of Patient: _____ Date of Birth: _____

Address:

Phone: _____

Name of Practice: _____ Phone: _____

Practice Address:

Statement of Medical Necessity:

☐ G47.33 Obstructive Sleep Apnea (Adult / Pediatric)
☐ G47.31 Primary Central Sleep Apnea
☐ _____ Other: _____

Provider Name: _____ Provider Signature: _____

Provider NPI: _____ Order effective on and signed on: _____

PAP Therapy Length of Need ☐ 90 days ☐ 1 year ☐ Other: _____

☐ Auto Titrating PAP: E0601 Min ____ cmH_2O (4 cmH_2O) and Max ____ cmH_2O (20 cmH_2O) Fixed at ____ cmH_2O

☐ CPAP: E0601

☐ Auto Bi-level PAP: E0470 iPAP max ____ cmH_2O; ePAP min ____ cmH_2O; PS max ____ cmH_2O

☐ Please fit Mask per patient comfort and include necessary headgear and cushions.

☐ Heated Humidifier: E0562 (1) ☐ Standard Tubing: A7037 (1) ☐ Filters Disposable: A7038 (1)

Mask, Accessories and Supplies (Count in parentheses)

☐ Mask - Full Face: A7030 (1)
☐ Full Face Cushion: A7031 (1)
☐ Mask - Nasal or Pillow: A7034 (1)
☐ Nasal Pillow: A7033 (2)
☐ Nasal Cushion: A7032 (2)
☐ Headgear: A7035 (1)
☐ Chinstrap: A7036 (1)
☐ Filters Non-disposable: A7039 (1)
☐ Heated Tubing: A4604 (1)

☐ Other:
☐ Other:
☐ Other:
☐ Other:

Mask, Accessories and Supplies (Replacement Schedule) *

Masks (All types): _____ Headgear (All types): _____
Cushion (Full face): _____ Cushions (Nasal/Pillow):_____
Tubing (All types): _____ Water chamber/tank: _____
Filter (Disposable): _____ Filter (Non-disposable): _____

** Enter number of replacements ordered per time period (ex: 1 per 90 days)*

Dental Appliance Therapy

☐ Dental Appliance (per patients choice)
☐ Post-Appliance Sleep Test (to verify effective)

PAP Compliance Reporting

☐ First 30 days of treatment
☐ Other: _____

Send completed Confirmation of Medical Order to selected treatment provider with Clinical Note, Snap Report, and Patient Insurance information. Do not send to Snap.

MK-065 Rev J