

CERTIFICATE OF MEDICAL NECESSITY

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

SECTION A		Certification Type/Date: _____	INITIAL ___/___/___	REVISED ___/___/___
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER		
_____ HICN _____		_____ NSC # _____		
PLACE OF SERVICE _____	HCPCS CODE _____ _____ _____	PT DOB ___/___/___; Sex ___ (M/F); HT. ___ (in.); WT. ___ (lbs.)		
NAME and ADDRESS of FACILITY if applicable (See Reverse)		PHYSICIAN NAME, ADDRESS (Printed or Typed)		
		PHYSICIAN'S UPIN: _____		
		PHYSICIAN'S TELEPHONE #: (____) _____-_____		

SECTION B		Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.	
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____	
ANSWERS	ANSWER QUESTIONS 12 AND 14 FOR CPAP (Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)		
	Questions 1 - 11, and 13, reserved for other or future use.		
__ __	12. How many episodes of apnea lasting greater than 10 seconds does the patient have during 6-7 hours of recorded sleep? (Number of episodes) (If greater than 99, enter 99.)		
Y N D	14. Does the patient have obstructive sleep apnea?		

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
 NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C	Narrative Description Of Equipment And Cost
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option. (See Instructions On Back)	

SECTION D	Physician Attestation and Signature/Date
I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.	
PHYSICIAN'S SIGNATURE _____	DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)