ClassicSleepCare LLC®
Healthy Sleep. Beautiful Smiles.®

Prescription for Durable Medical Equipment / Certificate of Medical Necessity

Patient Name ____________________ Gender ________ DOB ____ / ____ / ____
Address ____________________ Social Security ____________________
City, State, Zip ____________________ Primary Ins Co ____________________
Email Address ____________________ Primary Ins ID# ____________________
Primary Phone (____) ____ - ________ ☐ Cell ☐ Work ☐ Home Secondary Ins Co ____________________
Backup Phone (____) ____ - ________ ☐ Cell ☐ Work ☐ Home Secondary Ins ID# ____________________

MEDICAL NECESSITY

*Check all boxes that apply to patient's condition.

	Condition		
☐	Obstructive Sleep Apnea	(327.23)	(G47.33)
☐	Central Sleep Apnea	(327.27)	(G47.31)
☐	Complex Sleep Apnea	(647.37)	(G47.37)

PAP EQUIPMENT

*All machines have SmartCards and / or modems.

	Code	Item	Setting	
☐	**E0601**	CPAP Unit	________	cmH20
☐	**E0601**	Auto CPAP	_____ - _____	cmH20
☐	**E0470**	Bilevel Unit	_____ / _____	cmH20
☐	**E0470**	Auto Bilevel	_____ - _____	cmH20

☐ **E0471** Bilevel S/T
EPAP: ____________ IPAP: ____________
Rate: ____________ Other: ____________

☐ **E0471** Bilevel S/V
EPAP Min: __________ EPAP Max: __________
PS Min: __________ PS Max: __________
Max pressure: ________ Other: __________

☒ **A9279** Compliance Monitoring Modem
☒ **94660** RT Evaluation and PAP Setup
☐ Other: ______________________________

HUMIDIFIER

☒ **E0562** Heated CPAP Humidifier

CPAP / BI-LEVEL SUPPLIES

The following dispensable supplies are necessary for proper use of the equipment. They are not included with the PAP machine when purchased and need to be replaced on a regular basis.

☐ **All CPAP Supplies (Non Medicare Patients Only)**

	Code	Item	Frequency
☐	**A7027-A7029**	Hybrid Mask/Cushions	*Quarterly*
☐	**A7030**	Full Face Mask	*Quarterly*
☐	**A7031**	Face Mask Flap	*Monthly*
☐	**A7032**	Seals / Cushions / Flaps	*Bi-Weekly*
☐	**A7033**	Nasal Pillows	*Bi-Weekly*
☐	**A7034**	Nasal Application Device	*Quarterly*
☐	**A7035**	Headgear	*Semi-Annually*
☐	**A7036**	Chin Strap	*Semi-Annually*
☐	**A4604**	Tubing - Heated	*Quarterly*
☐	**A7037**	Tubing	*Quarterly*
☐	**A7038**	Filters - Disposable	*Bi-Weekly*
☐	**A7039**	Filters - Non-Disposable	*Semi-Annually*
☐	**A7044**	Oral Interface	*Quarterly*
☐	**A7046**	Replacement Water Chamber	*Semi-Annually*

START OF CARE DATE: ______________________

☐ **FIT FOR MASK** MASK:
☐ May substitute ☐ Do not substitute

PATIENT TYPE ☐ Medicare ☐ Non-Medicare
LENGTH OF NEED ☐ 99 / Lifetime ☐ Other ________

STATEMENT OF MEDICAL NECESSITY: The above referenced patient has an absolute Medical Necessity for the item(s) listed above. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the standards of medical practice for this patient's condition. The duration of the equipment/supplies will be lifetime unless otherwise indicated here: ____________________

Physician name ____________________ NPI # ____________________
Office phone (____) ____ - ________ Address ____________________
Office fax (____) ____ - ________ City, State, Zip ____________________

Signature ____________________ Today's date ____________________

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