RESTORATION MEDICAL SUPPLIES
73-26 YELLOWSTONE BLVD. FOREST HILLS NY 11375 | P: 718-268-5505 | F: 718-268-5506

Certificate of Medical Necessity for Medical Equipment

Order Date:	_____	**Height:**	_____
Patient Name:	_____	**Weight:**	_____
Date of Birth:	_____	**Insurance:**	_____
Address:	_____	**Insurance #:**	_____
	_____	**Place of Service:**	_____
City:	_____	**Length of Need:**	
State:			
Zip Code:	_____		

_____recently had a sleep study at a certified sleep lab which included a diagnostic and titration study.

The AHI (apnea/hypopnea index) was_____per hour of sleep.

According to the DMERC for OSA, an AHI greater then equal to 5, and less than 15 events per hour will qualify the patient for Cpap if the patient exhibits the following symptoms and/or conditions:

My patient has exhibited:

_____Excessive daytime sleepiness, as documented by either a score of 10 on the Epworth Sleepiness scale or inappropriate daytime napping.

_____Impaired cognition or mood disorder

_____Hypertension

_____Ischemic heart disease or history of stroke

_____Cardiac arrhythmia

_____Pulmonary hypertension

_____CPAP has been tried and proven ineffective (tried and failed) the medical necessity criteria for the use of Bi-Level non-invasive positive pressure respiratory assist device (BIPAP) for the treatment of OSA have been met.

Comments:

Ordering Physician Information:

Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

NPI Number: _____

_____ _____

Physician's Signature: **Date:**