California Sleep Solutions
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PAP Referral Form

Patient Information

Patient Name:____________________ Gender: ☐Male ☐ Female SSN:___-__-____DOB:____/____/_____

Address:____________________City:______________State:_________Zip:___________

Home Phone:(_______)______-_______Work Phone:(______)______-________Mobile Phone:(_____)______-________

Insurance

Primary Carrier:____________________Subscriber ID:____________________Group:___________

Secondary Carrier:__________________Subscriber ID:____________________Group:___________

Referring Physician Information

Physician Name: ________________________Office Contact: ____________________

Phone: ________________Fax: ________________NPI: ________________________

Address: ____________________City: ______________State:_________Zip:___________

DME SET UP

Baseline AHI (5/hr <):__________

Length of time: ______years

- ❑ E0601 CPAP PRESSURE: _________cm H_2O (*Auto CPAP* indicate range or pressure)
- ❑ E0470 BiPAP PRESSURE: _____/_____cm H_2O
- ❑ E0470 *AUTO* BiPAP PRESSURE: EPAP min:______cm H_2O, IPAP max:______cm H_2O, PS min_____cm H_2O, PS max_____cm H_2O
- ❑ E0471 ASV PRESSURE: EPAPmax____cmH_2O, EPAPmin____cmH_2O, IPAPmax____cmH_2O, PSmin____cmH_2O, PSmax____cmH_2O, rate____
  - or BiPAP ST PRESSURE:_____/_____cm H_2O, Backup rate:______
- ❑ E0562 Heated Humidifier
- ❑ Supplies__________

One per month: FULL FACE CUSHION A7031, NASAL CUSHIONS A7032, NASAL PILLOWS A7033, FILTERS A7038 , ORAL CUSHION FOR ORAL/NASAL A7028, NASAL PILLOWS FOR ORAL/NASAL MAKS A7029

One per 3 months: FULL FACED MASK A7030, NASAL MASK A7034, TUBING A7037, HEATED TUBING A4604, ORAL/NASAL MASK A7027

One per 6 months: HEADGEAR A7035, FILTER (NON-DISPOSIBLE) A7039, WATER CHAMBER A7046, CHIN STRAP A7036

CPAP therapy is the gold standard to treat Sleep Apnea. Heated Humidifiers are needed to prevent nasal congestion and dryness. Periodic replacement of supplies is needed to maintain compliance of therapy.

MEDICAL DIAGNOSIS

For medical necessity, please check all that apply:

- ❑ G47.33 OBSTRUCTIVE SLEEP APNEA
- ❑ R09.02 HYPOXEMIA
- ❑ G47.31 PRIMARY CENTRAL APNEA
- ❑ G47.36 SLEEP RELATED HYPOVENTILATION / HYPOXEMIA IN CONDTIONS CLASSIFIABLE ELSEWHERE
- ❑ G47.37 CENTRAL SLEEP APNEA IN CONDITIONS CLASSIFIED ELSEWHERE
- ❑ OTHER:__________________ (PLEASE SPECIFY)

Physician Signature:____________________________Date:____________

BY SIGNING ABOVE, I AUTHORIZE THE USE OF THIS DOCUMENT AS A LEGAL PRESCRIPTION, AND CERTIFY THAT THE PRESCRIBED IS MEDICALLY NECESSARY, REASONABLE AND NOT BEING PRESCRIBED FOR CONVENIENCE.

Thank you for your referral. Please fax **this form** together with copies of the patient's **insurance cards, clinical notes** and **sleep study** to 916.789.0529. Please contact us with any questions at 916.789.0112.