IEHP Covered CA Prescription for Durable Medical Equipment

Patient Name:	Gender:
Street Address:	DOB:
City, State, Zip:	Primary Insurance:
Email Address:	Insurance ID:
Primary Phone:	Secondary Insurance:
Secondary Phone:	Insurance ID:

Medical Necessity (Diagnosis) *Check all that apply
☐ G47.33 - Obstructive Sleep Apnea
☐ G47.31 - Central Sleep Apnea
☐ Other:

PAP Equipment *Check and fill in the PAP settings		
Machine	**CPT Code**	**Pressure Settings**
☐ CPAP	E0601	cm/H2O
☐ CPAP Auto	E0601	Minimum: cm/H2O Maximum: cm/H2O
☐ BiPAP	E0470	IPAP: cm/H2O EPAP: cm/H2O
☐ BiPAP Auto	E0470	Max IPAP: cm/H2O Min EPAP: cm/H2O Min PS: cm/H2O Max PS: cm/H2O
☐ BiPAP ST	E0471	IPAP: cm/H2O EPAP: cm/H2O Backup Rate: Timed Inspiration: Rise Time
☐ BiPAP ST AVAPS	E0471	IPAPmin: cm/H2O IPAPmax: cm/H2O EPAP: cm/H2O Tidal mL Backup Rate: BPM Timed Inspiration: Rise Time:

Pap Supplies	**Frequency Limit**	**Quantity**
A4604 – Heated Tubing	One Per Three Months	2
A7030 – Full Face Mask	One Per Three Months	2
A7031 – Full Face Cushion	One Per Month	6
A7032 – Nasal Cushion	Two Per Month	12
A7033 – Nasal Pillow	Two Per Month	12
A7034 – Nasal Mask	One Per Three Months	2
A7035 – Headgear	One Per Six Months	1
A7036 – Chin Strap	One Per Six Months	1
A7037 – Tubing	One Per Three Months	2
A7038 – Disposable Filter	Two Per Month	12
A7039 – Reusable Filter	One Per Six Months	1
A7046 – Water Chamber	One Per Six Months	1
E0562 – Heated Humidifier	One Time Only	1

PAP Equipment cont. *Check and fill in the PAP settings		
Machine	**CPT Code**	**Pressure Settings**
☐ BiPAP ST AutoSV	E0471	Min EPAP: cm/H2O Max EPAP: cm/H2O Min PS: cm/H2O Max PS: cm/H2O Max Pressure: cm/H2O Backup Rate: BPM
Other:		

Statement of Medical Necessity

The patient indicated has an absolute medical necessity for the items listed above. I certify that the items prescribed are reasonable and medically necessary with reference to the standards of medical practice for this patient's diagnosis. The length of need for the equipment and supplies will be **lifetime.** *(Unless otherwise indicated)

*Length of need will end on the following date: (Only list a date if not lifetime)

Physician Signature **Physician Name (Printed)** **Date Signed** **NPI Number**