QUALITY DME
DURABLE MEDICAL EQUIPMENT
Your Local CPAP/BIPAP/APAP Provider

Serving Maryland, DC & Virginia
Toll Free Phone: 888-276-3237
Main Fax: 703-288-4388
Toll Free Fax: 888-323-8429

Certificate of Medical Necessity

Patient Information:

Name:	DOB:	Gender:

Diagnosis: *Indicate secondary diagnosis if AHI is less than 15*

☒ G47.33 OSA	☐ Excess day. sleepiness	☐ Hypertension	☐ Insomnia	AHI:	_____/hr.
☐ G47.37 CSA	☐ Impaired cognition	☐ Mood disorder	☐ Hx of stroke	Length of Need:	99 (99=Lifetime)
				Order Start Date:	_____

Sleep Therapy:

☐ **CPAP (E0601)** Pressure:_____cm H_2O
- ☒ Ramp (Time):_____
- ☒ CFlex/EPR: 1 2 3
- ☒ Compliance Data

☐ **Auto CPAP (E0601):**
Min CPAP: _____cm H_2O
Max CPAP: _____cm H_2O

☐ **BiPAP (E0470)** Pressure: IPAP: _____ cm H_2O
EPAP: _____ cm H_2O
- ☒ Ramp (Time):_____
- ☒ BiFlex/EPR: 1 2 3
- ☒ Compliance Data

☐ **Auto BiPAP (E0470)**
EPAP Min: _____ cm H_2O Min PS: _____ cm H_2O
IPAP Max: _____ cm H_2O Max PS: _____ cm H_2O

☐ **BiPAP ST (E0471)**
IPAP: _____ cm H_2O
EPAP: _____ cm H_2O
Backup Rate: _____ bpm

☐ **Auto BiPAP ASV (E0471):**
Max Pres: _____ cm H_2O
EPAP Min: _____ cm H_2O
EPAP Max: _____ cm H_2O
Min PS: _____ cm H_2O
Max PS: _____ cm H_2O

Supplies:

☒ **Heated Humidifier (E0562)**
☐ Standard Tubing (A7037) 1 per 3 months
☒ Heated Tubing (A4604) 1 per 3 months
☒ All Standard Equipment:
- **Disposable Filter (A7038)** 2 per month
- **NonDisposable Filter (A7039)** 1 per 3 months
- **CPAP Headgear (A7035)** 1 per 3 months
- **Humidifier Chamber (A7046)** 1 per 6 months
- **Chinstrap (A7036)** 1 per 6 months
- **Wireless Modem (A9279)**

☐ Nasal Mask (A7034) 1 per 3 months
☐ Nasal Cushion (A7032) 2 per month

☐ Nasal Pillows Mask (A7034) 1 per 3 months
☐ Nasal Pillows (A7033) 2 per month

☐ Full Face Mask (A7030) 1 per 3 months
☐ Full Face Cushion (A7031) 1 per month

☐ Specific Mask Interface:
Model: _____
Size:_____
☐ Other/Notes:_____
_____

Oxygen Therapy:

☐ Stationary Concentrator (E1390)		Length of Need:	99 (99=lifetime)	
Diagnosis (ICD 10):		Frequency (select one):	☐ Nocturnal use only	☐ 24/7
Dosage: LPM	SaO2/PaO2:	Method of Delivery:	☐ PAP bleed-in	☐ Mask
Notes:			☐ Cannula	

Physician Information:

Name:	NPI#:
Location:	
Phone #:	Fax #:

Signature: _____ **Date Signed:** _____