BIPAP – Sleep Study Validation Form – E0470

Attn: Utilization Management
Phone 800-891-2520 Fax: 567-661-0846

(Must include DME Prior Authorization Form)

PATIENT INFORMATION

Patient Name ________________________________
DOB ________________________________
Phone Number ________________________________

Paramount ID# ________________________________
Paramount Secondary ID#: ____________________
(if applicable)

REFERRAL SOURCE

Referral Organization________________________________
Order Date ________________________________
Date of Clinical Evaluation________________________________

Ordering Physician Name ____________________
Phone Number ________________________________
Provider Billing Tax ID (TIN): ____________________

Face to Face Clinical Evaluation by Treating Practitioner perform prior to the Sleep Study: *Yes* ☐ *No* ☐

DIAGNOSIS ICD-10: A specific ICD-10 code must be provided

☐ G47.33 Obstructive Sleep Apnea (OSA) (Adult and Child) ☐ Other ________________________________
☐ Secondary condition ________________________________

HCPCS Code Requested: E0470 ☐ E0561☐ E0562 ☐

SLEEP STUDY ATTESTATION

Sleep Study Performed Date ____________________
Phone Number ________________________________

Site of Study ________________________________
Fax Number ________________________________

-AHI/RDI/REI Result: ≥ 15☐ ***or*** ≥ 5 and < 15 ☐
-OSA for an individual with coexisting hypoventilation or Intolerant to high pressures of CPAP or APAP: Yes ☐ No ☐
-The member met all required criteria for CPAP: Yes ☐ No ☐
-HCPCS Code E0601 ineffective: Y*es* ☐ No☐
-Instructions in the proper use and care of equipment given: Yes☐ No ☐
-Provider Attests Compliance for Continued PAP Use after 90 days: Yes ☐ No☐ N/A☐
-Retrial exception: Yes ☐ No ☐ N/A ☐ Comment: ________________________________

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the item(s) prescribed.

Print Provider's or DME Provider Name ________________________ NPI # ________________________
Provider's or DME Provider's Signature ________________________ Date ____________________

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