

CPAP - Sleep Study Validation Form – E0601

Attn: Utilization Management

Toll Free Phone 1-800-891-2520

Fax: 567-661-0846

(Must include DME Prior Authorization Form)

PATIENT INFORMATION

Member Name: _____

Paramount ID# _____

Secondary Paramount ID# _____

(if applicable)

Phone Number _____

DOB _____

REFERRAL SOURCE

Referral Organization _____

Ordering Physician Name _____

Phone Number _____

Date of Clinical Evaluation _____

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: E0601 E0561 E0562

SLEEP STUDY ATTESTATION

Order Date _____

Sleep Study Performed Date _____

Site of Study _____

Phone Number _____

Fax Number _____

AHI/RDI/REI Result: ≥ 15 or ≥ 5 and < 15

Symptoms of OSA if ≥ 5 and < 15 (Check All That Apply)

Excessive Day Time Sleepiness

Impaired Cognition

Mood Disorders

Insomnia

Hypertension

Ischemic Heart Disease

History of Stroke

PEDIATRIC ONLY (< 18 years of age)

Weight ≥ 30 kg/66 lbs: Yes No

Adenotonsillectomy: Unsuccessful Contraindicated

Definitive Surgery is indicated but must await complete Dental and Facial Development: Yes No

AHI > 1.5: Yes 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

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 _____

Provider Billing Tax ID (TIN): _____

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