# Home Titration - E0601 Attestation Form

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

**(Must include DME Prior Authorization Form)**

Member Name ___________________________________

Paramount ID# ________________________________

Paramount Secondary ID#:_____________________________
(if applicable)

DOB ___________________________________________

Phone Number ______________________________

**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* ☐

Provider Billing Tax ID (TIN):________________________________________

**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* ☐

**HOME TITRATION CRITERIA**

The individual does not have any comorbid conditions that would be expected to degrade the accuracy of Auto Titration as indicated in the Medical Policy: 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 ☐

Follow up Home Titration using APAP is considered medically necessary when all the following criteria are met as indicated in the Medical Policy: Yes ☐ No ☐

**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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