

Name of provider: _____

Provider NPI # _____

Medicaid Legacy # _____

Ohio Department of Job and Family Services
Certificate of Medical Necessity/Prescription
Positive Airway Pressure Devices
 CPAP (EO601) or APAP (Bi-Level-EO470) in lieu of CPAP

Initial (Complete Section A,B,D) **Recertification (Complete Sections A,C,D)**

Instructions: The Certificate of Medical Necessity (CMN) must be used for approved equipment under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of recipient:	Billing Number:	Date of Birth ____/____/____
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Initial rental dates:	For Recertification. Initial approved PA #:
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Section A—Must be completed by physician

Pertinent Diagnosis(es)—include ICD-9 code and description

Yes No Are there correctable causes (e.g., through surgery, medication, behavior modification, etc.) of the patient's sleep apnea? If yes, specify causes and describe treatment plan.

Section B—Initial Certification—Must be completed by physician

Polysomnogram/PAP titration report may be attached in lieu of completing this section

<input type="checkbox"/> Yes <input type="checkbox"/> No Was sleep study was performed? If "no", explain:	If "yes", where was sleep study performed? <input type="checkbox"/> Hospital sleep lab <input type="checkbox"/> Freestanding, accredited sleep lab <input type="checkbox"/> Other, specify:
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<input type="checkbox"/> Yes <input type="checkbox"/> No Was CPAP tried? <input type="checkbox"/> Yes <input type="checkbox"/> No Was CPAP effective?	<input type="checkbox"/> Yes <input type="checkbox"/> No Was oxygen used in conjunction with CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No Was Bi-Level (APAP) tried and effective?
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Results of Diagnostic Polysomnogram

Date: ____/____/____

Results of Titration Study on Optimal Airway Pressure

Date: ____/____/____

Combined obstructive apnea/hypopnea index: _____ Minimum O2 saturation on room air: _____ Hours of recorded sleep: _____ Number of episodes: _____	Combined obstructive apnea/hypopnea index: _____ Minimum O2 saturation on room air: _____ Hours of recorded sleep: _____ Number of episodes: _____
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Section C—Recertification—Must be completed by physician

Please indicate the device initially prescribed: (check one) <input type="checkbox"/> CPAP E0601 <input type="checkbox"/> Bi-Level (APAP) E0470	Recertifying for: <input type="checkbox"/> Additional _____ months rental, or (check one) <input type="checkbox"/> Purchase
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Yes No Is the patient using the device as prescribed? If "no", explain:

The patient is using CPAP (or APAP) device: Daily or On average, _____ days per week

for _____ hours/day

Yes No Is patient continuing to benefit from the device?

On optimal PAP, is patient Symptomatic? Asymptomatic?

Section D—Prescription, Physician Attestation and Signature/Date

E0601-CPAP Rx	Hours of PAP use: _____	E0470-Bi-Level Rx	Hours of PAP use: _____
CPAP level: _____	Humidification: <input type="checkbox"/> Heated	APAP level: ____/____	Humidification: <input type="checkbox"/> Heated
Ramp: _____	<input type="checkbox"/> Cool	Ramp: _____	<input type="checkbox"/> Cool

Physician's name (PRINTED)

I certify that I am the physician identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Physician signature: (No stamps)	Date: ____/____/____	Ohio Medicaid Provider #:
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