



Fax 480.895.2949

Phone 480.802 0202

Referred by _____

*****Valley Wide Service*****

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Patient's Phone: (Home) _____ (Cell) _____ (Work) _____

*****Please Send a Copy of All Insurance Cards With This Form*****

☐ C-PAP _____ cm H₂O ☐ Auto C-PAP _____ cm H₂O ☐ Bi-PAP IPAP _____ EPAP _____

☐ Bi-PAP ST IPAP _____ EPAP _____ BR _____

☐ Bi-PAP ASV IPAP Max _____ EPAP Min _____ EPAP Max _____ Min PS _____

MASKS:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | E0562 Heated Humidifier |
| <input type="checkbox"/> | A7034 Nasal Application Device 1 per 3 months |
| <input type="checkbox"/> | A7032 Seals/Cushions/Flaps 2 per months |
| <input type="checkbox"/> | A7030 Full Face Mask 1 per 3 months |
| <input type="checkbox"/> | A7031 Face Mask Cushion/Flap 1 per month |
| <input type="checkbox"/> | A7034 Nasal Application Device 1 per 3 months |
| <input type="checkbox"/> | A7033 Nasal Pillows 2 per month |
| <input type="checkbox"/> | A7027 Mask 1 per 3 months |
| <input type="checkbox"/> | A7028 Cushions 2 per month |
| <input type="checkbox"/> | A7029 Nasal Pillows 2 per month |
| <input type="checkbox"/> | A7044 Oral Interface 1 per 3 months |
| <input type="checkbox"/> | A7031 Face Mask Cushion/Flap 1 per month |

ACCESSORIES:

- | | |
|-------------------------------------|--|
| <input checked="" type="checkbox"/> | A7035 Headgear 1 per 6 months |
| <input checked="" type="checkbox"/> | A7036 Chin Strap 1 per 6 months |
| <input checked="" type="checkbox"/> | A7038 Filters-Disposable 2 per month |
| <input checked="" type="checkbox"/> | A7039 Filters-non-Disposable 1 per 6 months |
| <input type="checkbox"/> | A9279 Data Card |
| <input type="checkbox"/> | E1399 Misc. Equipment (wireless modem) |
| <input type="checkbox"/> | A7046 Replacement Water Chamber 1 per 6 months |

TUBING:

- | | |
|-------------------------------------|------------------------------------|
| <input checked="" type="checkbox"/> | A7037 Tubing 1 per 3 months |
| <input type="checkbox"/> | A4604 Heated Tubing 1 per 3 months |

Please mark at least one appropriate diagnosis:

- | | | | |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | Obstructive Sleep Apnea (ICD10 G47.33) | <input type="checkbox"/> | Hypersomnia w/Sleep Apnea (ICD10 G47.10) |
| <input type="checkbox"/> | Primary Central Sleep Apnea (ICD10 G47.31) | <input type="checkbox"/> | Central /Complex Sleep Apnea (ICD10 = G47.37) |
| <input type="checkbox"/> | COPD (ICD10 J44.9) | <input type="checkbox"/> | Other _____ |

Length of Need: ☒ Lifetime _____

The AHI or RDI is greater than or equal to 5 and less than or equal to 15 events per hour with a minimum of 10 events and documentation of additional symptoms noted in the patient's medical record. Please check documented symptoms below:

- ☐ Excessive Daytime Sleepiness/Hypersomnia ☐ Impaired Cognition ☐ Mood Disorders ☐ Hypertension
- ☐ Ischemic heart disease ☐ Insomnia ☐ History of stroke

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity on this form is true, accurate, and complete, to the best of my knowledge.

PHYSICIAN'S SIGNATURE: _____ Signature / Start Date: ____/____/____

Print Physician's Name _____ NPI _____