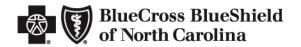
Use for Blue Medicare HMO/PPO Plans

Bi-Level Positive Airway Pressure (BiPAP) for Treatment of Obstructive Sleep Apnea Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Provider Informa	ation	Member Information	
Ordering Physician Name:	NPI #:	Member Name:	
Office Phone#: Office Fax#:	Contact Name:	Member ID #:	
Vendor Name:	NPI #:	Member's Date of Birth:	
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:	
ICD-10 Code(s):			
	Please answer quest	ions below	
HCPCS code(s) (REQUIRED):	-		
If this is a request for rental, please p	rovide the following info	rmation:	
1. What is the start date of the rental?	//_		
	•	treating physician to assess for obstructive sleep	
3. Did the member have a positive sle	eep test result that meets c	one of the following criteria (a or b and c)?	
		nce Index (RDI) is ≥ 15 events per hour? ☐ Yes ☐ No	
b. The AHI or RDI is ≥ 5 with ≤ 14	events per hour with docu	mented symptoms of:	
Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, OR			
Hypertension, ische	mic heart disease, or histo	ry of stroke	
	•	ed on a therapeutic trial/titration conducted in a facility ———————————————————————————————————	
		m the vendor in the proper use and care of the	
If this is a request for PURCHASE after completion of a 3-month rental period, please provide the following information:			
		day period? (This is 21 out of 30 days via a	
compliance chip or sleep record)?		☐ Yes ☐ No	
2. If no, please provide a copy of the	compliance download for r	eview.	



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If the member does not meet the compliance requirement above, provide the following information for review of one additional month's rental.		
1.	Were there extenuating circumstances which prevented the member from being compliant with use of Bi-Level Positive Airway Pressure Device (BIPAP)?	
2.	If yes, please provide reason(s) (i.e. hospitalization or illness, issues with fit of mask or machine function).	
3.	Has the member been educated on importance of compliance?	
I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.		
Sign	Signature: Date:	

Please Return Completed Form to:

Fax 1-336-794-1556

For questions, please call Care Management at 1-888-296-9790.

Blue Cross and Blue Shield of North Carolina is an HMO/PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.