Use for Experience Health Medicare Advantage SM (HMO)

Continuous Positive Airway Pressure (CPAP) Rental or Purchase Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Provider Information		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 questions below

HCPCS code(s) (REQUIRED): _____

If this request is for an INITIAL 3-MONTH RENTAL, please provide the following information:

1. What is the start date of the rental? _ _/_ _/_ _ _ _
2. Did the member have a face-to-face clinical evaluation by the treating physician to assess for obstructive sleep apnea prior to the sleep test? ..... ☐ Yes ☐ No
3. Did the member have a positive sleep test result that meets one of the following criteria?
   a. The Apnea Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is ≥ 15 events per hour? ..... ☐ Yes ☐ No
   b. The AHI or RDI is ≥ 5 with ≤14 events per hour with documented symptoms of:
      ☐ Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, **OR**
      ☐ Hypertension, ischemic heart disease, or history of stroke
      ..... ☐ Yes ☐ No

   If a or b above is not met, please submit a copy of the member's relevant medical records for review.
4. Has the member and/or the caregiver received instruction from the vendor in the proper use and care of the equipment? ..... ☐ Yes ☐ No

If this request is for PURCHASE after completion of a 3-month rental period, please provide the following information:

1. Did the member use the device at least 4 hours, 70% of a 30 day period? (This is 21 out of 30 days via a compliance chip or sleep record)? ..... ☐ Yes ☐ No

   If no, please provide a copy of the compliance download for review.

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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 the CPAP? ..... ☐ Yes ☐ No
2. If yes, please list reasons (i.e. hospitalization or illness, issues with fit of mask or machine function).

   _____
3. Has the member been educated on the importance of compliance? ..... ☐ Yes ☐ No

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 Experience Health Medicare Advantage SM (HMO) may request medical records for this patient at any time in order to verify this information.

Signature:_____ Date: _____

Please Return Completed Form to:
Fax 1-919-765-7805
For questions please call Care Management at 1-833-941-0107

Experience Health Medicare Advantage SM is a HMO plan. This plan has a Medicare contract. Enrollment in the plan depends on contract renewal.