Medoville Inc.
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Hagerstown, MD 21742
Phone: 888-630-2334
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110 Baughmans Lane,
Suite 106 Frederick, MD
21702
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Physician's Order & Certificate of Medical Necessity Form

PLEASE INCLUDE PATIENT DEMOGRAPHICS, SLEEP STUDIES & FACE TO FACE EVALUTION SHEETS

PATIENT INFORMATION

Name:_____ Date of Birth:_____

Address:_____

City/State/Zip Code:_____ Emergency Contact/Phone #: _____

Social Security #:_____ Home Phone :_____

INSURANCE INFORMATION

Insurance Company Name: _____ Insurance Company Phone #:_____

Guarantor Name:_____ Guarantor Date of Birth: _____

Group #:_____ I.D. #: _____

DIAGNOSIS

☐ Obstructive Sleep Apnea (Adult & Child) (G47.33) ☐ Primary Central Sleep Apnea (includes Complex Sleep Apnea) (G47.31)

☐ Other (Please indicate ICD-10 with description) _____

PRESCRIPTION

Start of Care Date: _____/_____/_____ **Length of Need (in months)**: _____ (1-99, 99 = lifetime)

PAP Equipment

☐ CPAP (E0601) Pressure _____cm H_2O

☐ Auto PAP (E0601) Pressure _____ - _____cm H_2O

☐ BiPAP (E0470) IPAP_____ cm H_2O, EPAP _____cm H_2O

☐ Heated Humidification (E0562)

Ramp Time_____min(s) (Off – 45min)

☐ PAP Replacement Machine
(Current Machine Broken Beyond Repair)

☐ Other _____ (HCPCS _____)

PAP Supplies

☐ Full Face: ☐ Mask[3] (A7030) ☐ Cushion[2] (A7031) ☐ Headgear[4] (A7035)

☐ Nasal: ☐ Mask[3] (A7034) ☐ Cushions[1] (A7032) ☐ Headgear[4] (A7035)

☐ NP System: ☐ Mask[3] (A7034) ☐ Pillows[1] (A7033) ☐ Headgear[4] (A7035)

Size ☐ XS ☐ S ☐ M ☐ L ☐ Fit to Size

☐ Heated Tubing[3] (A4604) ☐ Regular Tubing[3] (A7037)

☐ Filters-Disposable[1] (A7038) ☐ Filters-Non Disposable[4] (A7039)

☐ Humidifier Tub[4] (A7046) ☐ Chinstrap[4] (A7036)

Medicare Frequency of Need: 1 = 2/month, 2 = Monthly, 3 = Quarterly, 4 = Semi-Annually

I certify that the above services are required, medically necessary and authorized by me. This patient is under my care, and is in need of the services specified herein. This document may serve as written confirmation of a verbal order, and the information above is contained in the patient's medical record.

Physician Signature: _____ **Date:**_____
(Same as start date unless otherwise noted)

Physician Name (printed):_____ **NPI #:** _____

Address:_____ **City:** _____ **State:**_____ **Zip:**_____

Phone:_____ **Fax**: _____

Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

Please specify the date of the patient's follow-up appointment: _____/_____/_____