

Certificate of Medical Necessity (CMN) for: Continuous Positive Airway Pressure

Date: ____/____/____ Requesting Provider: _____

Pt. Name: _____ I.D. Number: _____

1. Does the patient have a diagnosis of Obstructive Sleep Apnea by polysomnogram? Y N

2. Enter the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI).

3. Is the Obstructive Sleep Apnea suspected to be causing Dysrhythmia(s)? Y N

4. What additional clinical diagnoses does this patient have? (Circle)

- a. Excessive daytime sleepiness
- b. Impaired cognition
- c. Mood disorders
- d. Insomnia
- e. Hypertension
- f. Ischemic heart disease
- g. History of stroke

5. Results of CPAP Trial (at Optimum CPAP Pressure)

a. Enter the AHI or RDI at optimum CPAP _____

b. During the Trial, what was the Lowest Oxygen Saturation? _____ %

c. Did CPAP correct the Dysrhythmia(s)? Y N D

6. Does the patient have clinically significant Congestive Heart Failure? Y N

Contact Name: _____ Phone : _____

Physician Signature (Stamps are not acceptable) Date

Key - (Y)es, (N)o, (D)oes not apply

Requested Information:

- 1. Typed office note with pertinent information.
- 2. All sleep study documentation