Medical Management & Policy Services
Fax Number: 412-544-2921

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

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