



# CPAP SPECIALISTS

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[www.CPAPSpecialist.com](http://www.CPAPSpecialist.com)

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## Physician's Letter of Medical Necessity and Nasal PAP Prescription

Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ Insurance: \_\_\_\_\_

**Dispensing location:**  CPAP Specialists  Doctor's Office  Patient Home  
 Hospital  Other \_\_\_\_\_

**Diagnosis:**  Obstructive Sleep Apnea (OSA)  Other: \_\_\_\_\_

Due to the above diagnosis, PAP unit is required for this patient. I, the undersigned certify that this prescription is reasonable and necessary according to the accepted standards in treatment and is not prescribed as a convenience device. The above named patient, if left untreated, remains at risk for cardiac arrhythmia, high blood pressure, and other symptoms associated with obstructive sleep apnea.

Additionally, the use of this device will improve sleep architecture disruption resulting from obstructive sleep apnea, as well as long term reversal of symptoms (such as excessive daytime somnolence, irritability, difficulties in concentration, falling asleep inappropriately, forgetfulness and depression). Documentation supporting this diagnosis are available upon request. CPAP Specialists is authorized to dispense the equipment brand that ensures patient's comfort and compliance.

### CPAP Equipment required:

- CPAP at Pressure \_\_\_\_\_ cm H2O with heated humidifier and Nasal Mask.
- Auto-CPAP at min Pressure \_\_\_\_\_ cm H2O, max Pressure \_\_\_\_\_ cm H2O with heated humidifier and Nasal Mask.
- BiPAP, Spontaneous, at IPAP Pressure \_\_\_\_\_ cm H2O and EPAP Pressure \_\_\_\_\_ cm H2O with heated humidifier and Nasal Mask.
- BiPAP, Timed, at IPAP Pressure \_\_\_\_\_ cm H2O and EPAP Pressure \_\_\_\_\_ cm H2O with heated humidifier and Nasal Mask.

Mask:  Nasal mask  Full face mask  Pillow mask  Other:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name:**

**Please include:**  Sleep Studies, etc.  Copy of insurance card **Fax: (866) 442-7632**