VERIO HEALTHCARE

Certificate of Medical Necessity/Order – Pap

Member Name: _____ DOB: ____/_____/_____

Address: _____ CIN: _____

City: _____ Ca. Zip: _____ _____

PH: _(_____)_____-_____

Equipment Prescribed:

____ CPAP Unit (E0601) ____ BiPAP Unit (E0470)

____ BiPAP Unit w/Back up Rate (E0471)

____ Humidifier, Heated (E0562)

____ Other: _____

Pressure: CPAP @ _____cm H2O **BiPAP** @ ____/_____ CM H2O back up rate: _____

Delivery Method: ___ nasal mask ___ full face mask ___ nasal pillows ___ other: _____

Length of need (# of months): _____

Diagnosis(s) ICD-10: _____

Notes: _____

_____

_____ _____/_____/_____

MD Signature Date

MD Name: _____ NPI: _____

Phone#: _____