U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

CERTIFICATE OF MEDICAL NECESSITY

FORM APPROVED
OMB NO. 0938-0679
DMERC 03.02

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

SECTION A **Cert Type/Date:** Original **INITIAL** 11/7/19 **REVISED** **RECERTIFICATION**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

Sawako Yamanaka
1237 Street
City, MI 43453

1381

(555) 555-5632 HICN 384239787

SUPPLIER NAME, ADDRESS, TELEPHONE, FAX, NSC NUMBER

xxxxxxxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxx
xxxxxxxxxxxxxxx
xxxxxxxxxxxxxxx, AR 11111
(111) 111-1111 Fax: (111) 111-1111 1111 NSC #

PLACE OF SERVICE 12
NAME and ADDRESS of FACILITY if applicable (See Reverse)

Home

HCPCS CODE

PT DOB 09/08/1977 Sex F (M/F) HT. (in.) WT (Lbs.)

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER
test ask
109 ROLAND
P O BOX 85
MCBAIN, WY 49657
(555) 555-4565 NPI orUPIN # 1184605313 Fax: (234) 567-8902

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): **1-99 (99=LIFETIME)** ____

DIAGNOSIS CODES (ICD-9): ____ ____ ____ ____

ANSWERS	ANSWER QUESTIONS 12 AND 14 FOR CPAP (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
	Questions 1-11, and 13, reserved for other future use.
____ ____	12. How many episodes of apnea lasting greater than 10 seconds does the patient have during 6-7 hours of recorded sleep? (Number of episodes) (If greater than 99, enter 99.)
Y N D	14. Does the patient have obstructive sleep apnea?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. (*See Instructions On Back*)

E0466 Billing Code $10.00 Purchase
testing $100.00

$0.00

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omssion, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM CMS 845 (4/96)