GEISINGER HEALTH PLAN

DME NETWORK PRE-CERTIFICATION FORM

PHONE: 866-248-1972
LOCAL: 570-271-7127
FAX: 570-271-7171

*DME VENDOR: *GHP PROVIDER #:	*LOCATION: *OFFICE SITE #:	*PHONE NUMBER: *FAX NUMBER:	*FORM COMPLETED BY:
*MEMBER INFORMATION: Last Name First Name MI	*HEALTH PLAN ID:	BIRTHDATE:	

RESPIRATORY ASSIST DEVICE TYPE/MODEL:
Settings: _____IPAP _____ EPAP _____O2 Flow Back up rate (applicable): _____ Ramp: _____
Interface brand/size/headgear: _____ Other remarks:

GROUP I- RESTRICTIVE THORACIC DISORDERS
PaCO2 _____ on _____ (usual FiO2) Test date/Location: _____
or
Lowest Oxygen Saturation for 5 consecutive minutes while breathing usual FiO2 ( )
Results/Test Date/Location: _____
or
Maximal Inspiratory Pressure/Test Date/Location: _____
or
Forced Vital Capacity/% Predicted/Test Date/Location: _____
and
Documentation that COPD does not significantly contribute to the patient limitations (if so, by whom?)

GROUP II- SEVERE COPD
Has Obstructive Sleep Apnea (OSA) and CPAP Treatment been considered and ruled out? YES ____ NO _____
PaCO2 _____ on _____ (usual FiO2) Test Date: _____ Location: _____
Lowest Oxygen Saturation for 5 consecutive minutes while breathing 2 L/M or usual FiO2 ( ) whichever is higher during sleep?
Test Date: _____ Location: _____

GROUP III- CENTRAL SLEEP APNEA
Attended Polysomnogram Test Site: _____ Facility: _____ Date: _____ Inpatient: _____ Outpatient: _____
Lowest Oxygen Saturation for 5 consecutive minutes while breathing usual FiO2 ( )
Test Date: _____ Location: _____
OSA Excluded as predominant cause of sleep associated hyperventilation? YES ____ NO ____
CPAP has been ruled out as effective therapy if OSA is a component of the sleep associated ventilation? YES _____ NO ____
Demonstrated improvement documented using RAD type/settings that will be prescribed for initial use at home?
YES _____ NO _____ By Whom? _____

GROUP IV- OBSTRUCTIVE SLEEP APNEA
CPAP has been tried and found to be ineffective? YES _____ NO _____
Full attended Polysomnogram required.
Test Facility: _____ Location: _____
Outpatient Test Date: _____ Inpatient Test Date: _____

*Required Information. Incomplete forms will be returned unprocessed.

Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.