DME NETWORK PRE-CERTIFICATION FORM

**Phone:** 866-248-1972  
**Local:** 570-271-7127  
**Fax:** 570-271-7171

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<th><em>DME Vendor:</em></th>
<th><em>Location:</em></th>
<th><em>Phone Number:</em></th>
<th><em>Form Completed By:</em></th>
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<th><em>GHP Provider #:</em></th>
<th><em>Office Site #:</em></th>
<th><em>Fax Number:</em></th>
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| *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: |
|-------------------------------------------|-----------------|-------------|
| 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.