Positional obstructive sleep apnea (POSA) prescription/assessment form

RespirTech®

Fax to 833.461.0791 Questions? Call 833.916.1041

REQUIRED ATTACHMENTS: Patient demographic sheet | Copy of insurance card | Medical records

Patient information

Order date _____

Name (last) _____ (First) _____ M ☐ F ☐

Date of birth _____ Phone _____

Notes _____ Medical record # _____

_____ _____ _____ _____

Healthcare facility | Phone | Fax | Anticipated discharge date, if currently hospitalized

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

Medical necessity assessment: *This information must be supported in the patient's medical record and a copy of the record must accompany this prescription.*

Does patient have or have history of any of the below
(Check all that apply)

- ☐ Excessive daytime sleepiness
- ☐ Impaired cognition
- ☐ Mood disorders
- ☐ Insomnia
- ☐ Hypertension
- ☐ Ischemic heart disease
- ☐ History of stroke
- ☐ Other _____

Complete this section if sleep study was performed

Date sleep study was performed _____

Supine Apnea-hypopnea index (AHI) _____

Non-supine AHI _____

OR

Supine Respiratory Disturbance Index (RDI) _____

Non-supine RDI _____

℞: Positional obstructive sleep apnea (POSA) (HCPCS: K1001)

Check length of need *(Only check one option)*: ☐ **Lifetime (99)** ☐ Other _____
(If selected, must indicate # of months)

Diagnoses: *(List all primary and secondary diagnoses that apply.)*

1. _____ (Code) _____ 3. _____ (Code) _____
2. _____ (Code) _____ 4. _____ (Code) _____

I certify the information contained on this form is true, accurate, and complete to the best of my knowledge. This prescription is for POSA device from RespirTech, which, according to my professional judgment, is medically necessary for the patient identified above. The patient's record contains documentation supporting use of POSA device. I agree to provide such documentation to RespirTech and/or its authorized agents upon request. A copy of this order will be retained as part of the patient's medical record.

_____ _____

Practitioner signature | Date

(Original signature and date required, stamped signature and date not accepted.)

_____ _____

Practitioner name (print) | NPI *(required)*

RespirTech personnel may fill in practitioner name and NPI prior to practitioner signature and date.

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