Sleep Management Program

Utilization Management Request Checklist
Enter Sleep Study Results / Enter Compliance Results
W: https://www.ProviderPortal.com

Patient Name_____ DOB _____ Age _____

Health Plan_____ Member Number_____

Requesting Physician_____ Sleep Study Provider _____

DIRECTIONS:
Collect patient information from the requesting physician, servicing physician or durable medical equipment supply company. Submit online (https://www.ProviderPortal.com) to store on the member's profile for future use.

Category	**Order Type: Enter Sleep Study Results Only**
Testing Start Date	____/____/_____
Testing End Date	____/____/_____
Total Nights of Testing	
Max AHI Score	

Category	**Order Type: Enter Compliance Results Only**
PAP Device History	Which PAP device does the member have? ☐ APAP (Automatic Positive Airway Pressure)/E0601 ☐ CPAP (Continuous Positive Airway Pressure)/E0601 ☐ BPAP (Bilevel Positive Airway Pressure) with back-up rate feature/E0471 ☐ BPAP (Bilevel Positive Airway Pressure) without back-up rate feature /E0470
Member Initial Treatment Start Date	What is the start date of the member's initial treatment with the PAP device? ____/____/_____
Compliance Data	☐ CMS Compliance Standard Achieved ○ The CMS Standard is defined as 4+ hours/night of use >= 70% of the nights in 30 consecutive days over the reporting period. ☐ Average daily hours of use of the PAP equipment _____
Compliance Data Collection	How was this compliance data collected? _____ Directly from the device _____ Member attestation If member attestation was selected above, what is the make / model of the PAP equipment? _____