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SLEEP CARE SOLUTIONS, LLC  
&  
CARE SOLUTIONS, INC

FAX  
Miami 305.666.8801  
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Nash. 615.333.8380

**Statement of Medical Necessity**

**Patient Name:**

**Address:**

**City/St/Zip:**

**Phone:**

**DOB:**

**Gender:**

**Diagnosis #1:** OBSTRUCTIVE SLEEP APNEA

327.23

**Date Last Seen:**

**Diagnosis #2:**

**Prognosis:**

**Diagnosis #3:**

**Length of Need:** 99

**Diagnosis #4:**

**Access:** N/A

**This is to certify that the below listed items were ordered on: Order Date: 12/08/2009**

<b>Product Description</b>	<b>Quantity</b>	<b>Frequency</b>
A7034 Mask Fit For Patient Comfort	1	Q 3 Months
A7037 Tubing CPAP 6 foot	1	Q 3 Months
A7038 Filter Disp	2	Q Monthly
A7039 Filter ND	1	Q 6 Months
A7035 Headgear Deluxe	1	Q 6 Months
A7036 Chin Strap	1	Q 6 Months
A7046 Humidifier Water Chamber	1	Q 6 Months
A7032 Cushion For Replacement	2	Q 1 Month
A7033 Pillows For Replacement	2	Q 1 Month
A7030 Mask Full Face	1	Q 3 Months

**Statement of Medical Necessity:**

ORDER:

PAP Supplies as needed

**Physician's Certificate:**

I certify / recertify that the above listed products / services are  
Medically Necessary and that this patient is under my care.

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

UPIN:

NPI: \_\_\_\_\_