group health Cooperative of eau claire

Prior Authorization Form

CPAP Initial Application

Member: _____ DOB: _____ ID#: _____

Diagnosis: _____ CPT:_____

Physician Name :_____

Vendor :_____ Phone:_____ Fax:_____

AHI Result: _____

RDI Result: _____

Lowest Oxygen Saturation :_____

Choose all that apply:

- ☐ Snoring
- ☐ Failure to thrive
- ☐ Pulmonary hypertension
- ☐ OSA
- ☐ Central sleep apnea
- ☐ Daytime somnolence
- ☐ Other (please comment)

List comorbidities:

1. _____
2. _____
3. _____
4. _____

Please fax completed form to:

Group Health Cooperative of Eau Claire
Fax: 715-552-7202