PAP Compliance Cover Sheet

To request authorization for PAP purchase, please fax the following to 866-999-3510:

Start

1. **This completed compliance cover sheet**
2. **The summary compliance form obtained from the PAP device manufacturer's online system.**

1

Member Name:		DOB:	
Oscar ID#:			

2

Physician Name:		NPI:	
Address:		City / Zip:	
Phone:		Fax:	

3

DME Provider:		TIN:	
Address:		City / Zip:	
Phone:		Fax:	

Request type:

- ☐ E0601 CPAP Purchase
- ☐ E0470/E0471 Bilevel PAP Purchase

Please answer the following questions regarding this member's PAP usage during the first 3 months of therapy.

What date did this member start PAP therapy?	
Have the patient's symptoms improved based upon a conversation with the patient or the treating physician during this initial period of PAP therapy?	☐ yes ☐ no