HOME MONITOR INFORMATIONAL FORM

The following information is required when billing for home apnea monitors. Please complete the form and attach it to your claim. In addition, a copy of the physician signed Rx for the monitoring device, dated on or prior to the service date is required to be attached to your claim.

BENEFICIARY'S NAME _____

BENEFICIARY'S DATE OF BIRTH _____

BENEFICIARY'S ID NUMBER _____

PRESCRIBING PHYSICIAN _____

DATE HOME MONITORING BEGAN _____

LENGTH OF TIME MONITOR DEVICE WILL BE NECESSARY AS INDICATED BY THE PRESCRIBING PHYSICIAN _____

List diagnoses and/or conditions indicating medical necessity of home apnea monitoring as cited by the prescribing physician.

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If any of the following apply, please indicate the information requested:

- If the term(s) "apnea" and/or "bradycardia" are listed, a description of the initial episode and its length must be included as well as frequency and dates of apneic episodes while hospitalized.
- If bronchopulmonary dysplasia is listed, indicate whether or not the beneficiary utilizes home oxygen.
- If born prematurely, indicate either by how many weeks he/she was premature, the gestational age at birth, or the mother's expected date of delivery.

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If the beneficiary's age is over 6 months (or 6 months post-expected date of delivery in premature beneficiaries) and has utilized a home apnea monitor longer than 3 months, please indicate the medical necessity of continued monitoring as cited by the prescribing physician. Include date(s) of any apneic/bradycardic episodes requiring adult intervention.

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