Rev. 04/13

CERTIFICATION FOR INTERMITTENT ASSIST DEVICE (i.e., BIPAP)

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Member's Name_____

Member's Medicaid Number _____ DOB_____

Diagnosis:
☐ Obstructive sleep apnea ☐ Respiratory distress * Other: _____

Describe results of CPAP trial, if attempted:

_____

_____

Describe the member's current condition:

_____

_____

_____

Will the intermittent assist device provide an alternative to a Tracheotomy: ☐ Yes ☐ No

: _____

_____

BiPAP level IPAP_____ EPAP_____ RR_____

MD Signature: _____ Date of Signature: _____

MD's Printed Name: _____ Specialty: _____

Address:

Telephone:

RT or Certified Sleep Technologist providing training or fitting

Signature: _____ Date: _____

Certification Number: _____