

Prior Authorization Request
PO Box 30
Denver CO 80201-0030

Fiscal Agent for
Colorado Medicaid
ACS
Medical Review Department

303-534-0279
1-800-237-7647

QUESTIONNAIRE #7 APNEA MONITOR

Client Name: _____

Colorado Medicaid Client ID#: _____

Generally, a physician should be able to assess whether a client's medical condition necessitates the continued use of an apnea monitor beyond the initial 6-month monitoring period. Medical necessity must be documented for the continued use of an apnea monitor after this period.

The information requested below is required in order to determine medical necessity. If you have questions related to this Questionnaire or PAR, please contact the Medical Review Department at the phone numbers listed above. After you have completed this form, mail it with the completed Prior Authorization Request (PAR) to the address listed above. Thank you for your cooperation.

Relevant Diagnosis (es): _____

Client's age: _____ How frequently have apneic episodes occurred? _____

Dates: _____

Is apnea monitoring continuous? _____ At night only? _____ During feedings? _____

List all documented apneic episodes during the initial 6-month monitoring period: _____

Has client been hospitalized due to apneic episodes or related diagnosis? _____

If yes, what dates? _____

Is client on continuous oxygen? Yes No Is client using oxygen intermittently? Yes No

If so, how many liters per minute: _____

How long will client need apnea monitoring? _____

Please supply any additional information that will assist us in determining **medical necessity** for this request: _____

Physician Signature: _____ Date: _____

PLEASE PHOTOCOPY THIS BLANK FORM AS NEEDED