THE Great-West Life ASSURANCE COMPANY

Request for Coverage for Positive Airway Pressure Machine Assessment Form

INSTRUCTIONS:

1. Have your physician complete this form.
2. Attach the form and all receipts/estimate to your claim form. Retain copies of all documents for your records.
3. Submit your claim to the Benefit Payment Office indicated on your claim form.
4. **For Residents of Saskatchewan, Manitoba and Ontario:** You must apply for coverage through the appropriate Provincial Health Program before submitting a claim or estimate to Great-West Life.

Patient Name	Date of Referral:

Section 1: Complete for all Positive Airway Pressure System Devices:

1. What type of machine does the patient require? ☐ CPAP machine ☐ APAP machine ☐ BPAP machine

2. What type of request is this? ☐ Initial machine ☐ Replacement Machine **(Please proceed to Section 4)**

3. What type of sleep study did the patient participate in?
   ☐ Level 1 – Clinic/Lab Sleep Study ☐ Level 3 – In Home Sleep Study ☐ Other: _____
   Please attach a copy of the Sleep Study Diagnostic Report.

4. Which diagnosis does the Sleep Study confirm? (check one):
   ☐ Mild OSA ☐ Moderate OSA ☐ Severe OSA
   If a **Level 3 Sleep Study** was performed, how was the optimal pressure determined to treat the patient's apnea?

Section 2: Complete if requesting an APAP Device:

1. Does the patient have a documented diagnosis of sleep disorder where there is a change in pressure of a minimum of 4cm H2O on a prescribed fixed CPAP level of 10 cmH2O or more? ☐ Yes ☐ No

2. Does the change in pressure occur between REM vs. NREM or supine vs. non-supine? ☐ Yes ☐ No

Section 3: Complete if requesting a BPAP Device:

1. Does the patient have a documented diagnosis of OSA/OSAS and despite CPAP of 15 cmH2O or greater exhibits one of the following?
   ☐ Nocturnal hypoxemia (O2 saturation < 88%) ☐ Nocturnal hypercapnia (end tidal CO2) ☐ Apnea/hypopnea index > 10

2. Does CPAP of 15 cmH2O or greater resolve the physiological abnormalities but the patient is unable to tolerate this pressure? ☐ Yes ☐ No

3. Is the patient unable to tolerate any level of CPAP or continues to complain of excessive daytime sleepiness (EPWROTH score ≥ 10)? ☐ Yes ☐ No

Section 4: Replacement PAP Device:

1. What was the patient's previous device? ☐ CPAP ☐ APAP ☐ BPAP

2. What is the age of the current PAP device? _____(mmmm)/ _____(yyyy)

3. Please confirm why a replacement is required: (change in condition, machine cannot be repaired, etc.)

Form completed by:

_____
Referring Physician's name, registration number and designation (please print):

_____ Telephone number: _____
Physician's signature

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Clear