Security Health Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Oral Appliance for Obstructive Sleep Apnea

Pre-service Determination Request

Date ____________________________

Prior authorization is not required. However, an incomplete form may result in pre-service determination denial and/or denial of claims. Pre-service determination approval does not guarantee payment. Documentation must support billed charges.

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Ordering provider name (print)	Telephone number	Fax number
Place of service: ☐ Home ☐ Skilled nursing facility ☐ Other ______		
DME name		
Vendor contact name	Vendor telephone number	Vendor fax number
DME vendor address		

Procedure information		
Scheduled date of service or equipment to be received (month/day/year)	Requested service/procedure/DME	HCPCS code(s)

Diagnosis	Diagnosis code(s)

Answer all of the following questions.

The member has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the member for obstructive sleep apnea testing . . . . ☐ Yes ☐ No

Physician's name ______________________ Specialty ______________

Telephone no. ________________________

Assessment date (month/day/year) ______ /______ /______

The sleep test is ordered by the treating physician . . . . ☐ Yes ☐ No

Treating physician's name ______________________ Telephone no. __________

The member has a covered sleep test:

Sleep test performed by ____

Specialty ______________________ Telephone no. ______________

Sleep test read by ____

Specialty ______________________ Telephone no. ______________

 © 2017 Security Health Plan of Wisconsin, Inc.

The covered sleep test meets one of the following:

- The apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events
  OR
  AHI level ________________ Date ___________________ Number of events ______________
  RDI level ________________ Date ___________________ Number of events ______________ . ☐ Yes ☐ No
- The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
  – Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia . . . . ☐ Yes ☐ No
  OR
  – Hypertension, ischemic heart disease or history of stroke . . . . ☐ Yes ☐ No
- If the AHI or the RDI is greater than 30 and meets either of the following:
  – The member is not able to tolerate a positive airway pressure (PAP) device . . . . ☐ Yes ☐ No
  If yes, explain or provide documentation to support _________________________________
  ____
  OR
  – The treating physician determines that the use of a PAP device is contraindicated . . . . ☐ Yes ☐ No
  If yes, explain or provide documentation to support _________________________________
  ____

The device is ordered by the treating physician following review of the report of the sleep test . . . . . . ☐ Yes ☐ No

Treating physician name ___________________________ Telephone no. _____________________

The device is provided by a licensed dentist (DDS or DMD) . . . . ☐ Yes ☐ No

DDS or DMD name _______________________________ Telephone no. _____________________

Is this a replacement device . . . . ☐ Yes ☐ No

If yes, date of previous device (month/day/year) ______ /______ /______

Reason for replacement ____

____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

____ ________________________
Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.9918	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Provider Assistance at 1.800.548.1224.

 © 2017 Security Health Plan of Wisconsin, Inc.