CERTIFICATE OF MEDICAL NECESSITY FOR APNEA MONITORS
(To be completed by licensed practitioner or by the provider based upon medical necessity documentation by the licensed practitioner)

I certify that the information on this form is true and correct

Licensed Practitioner Signature:	Date:
Licensed Practitioner Name (please print):	Licensed Practitioner License Number:
Licensed Practitioner Address:	Licensed Practitioner Phone Number:
Patient Diagnosis (specific and complete, include any secondary diagnoses related to need for apnea monitor):	
Reason for prescribing apnea monitor: ❑ Apnea of prematurity ❑ A near-miss SIDS event ❑ An Apparent Life Threatening Event ❑ The apparently normal sibling of a SIDS victim; age of sibling at death _____ ❑ Other, please explain _____ _____ _____	Date of Service:

Patient Name:	Client Identification Number (CIN):	Date of Birth: Gestational age:
Provider Name and Address:		National Provider Identifier (NPI): Provider Phone Number:
Documentation of apnea of prematurity or an Apparent Life-Threatening Event: Documentation of a near miss Sudden Infant Death Syndrome:		
Polysomnography test results (if performed):		
Facility where test was administered:		
FOR REAUTHORIZATION REQUESTS: Documentation of medical justification for continued need of the apnea monitor:		