

CPAP/BIPAP Request Form

Use this form for NYC Employees PPO (NYCE PPO) plan members only. Medicare, Medicaid, FHP or SCHP have their own specific requirements; please do not use this form.

Please complete document or ensure clinical includes information noted below and upload to the NYCE PPO portal at nyceppo.com.

To _____	From _____
Fax _____	Fax _____
NYCE PPO reference # _____	Phone _____
Patient's full name _____	Pages (including cover) _____
Member ID _____	Date of birth _____ <small>MM/DD/YYYY</small>
Patient diagnosis code _____	HCPCS code(s) requested _____
Please check one <input type="checkbox"/> New <input type="checkbox"/> Replacement	

Important: Pricing must be submitted with request. Failure to include will result delays in determinations.

Please provide the following information to assist us in determining coverage of your patient's requested device:

For all requests

- Pricing
- Physician order
- Clinical records, including patient history and recent progress notes

For new requests

- Results of sleep study within the last 2 years (PSG, Split Night PSF or Titration PSG)

For BIPAP requests

- Documentation of CPAP tried and failed/ineffective

For replacement requests

- Current device out-of-warranty date and malfunction information

[UnitedHealthcare Commercial Medical & Drug Policies](#)

Note: If requested information is incomplete, payment for the claim may be denied.

Completion of the notification process is not a guarantee of claims payment. Claims payment is subject to member eligibility, benefits and application of coverage as outlined in the member's coverage documents.