



# 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 Canada Life.

Patient Name	Date of Referral:
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### 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
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2. What type of request is this?     Initial machine     Replacement Machine (**Please proceed to Section 4**)
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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.**
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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
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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
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2. Does CPAP of 15 cmH2O or greater resolve the physiological abnormalities but the patient is unable to tolerate this pressure?     Yes     No
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3. Is the patient unable to tolerate any level of CPAP or continues to complain of excessive daytime sleepiness (EPWORTH score ≥ 10)?     Yes     No

### Section 4: Replacement PAP Device:

1. What was the patient's previous device?     CPAP     APAP     BPAP
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2. What is the age of the current PAP device? \_\_\_\_\_ (mmmm)/ \_\_\_\_\_ (yyyy)
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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): \_\_\_\_\_

Physician's signature \_\_\_\_\_ Telephone number: \_\_\_\_\_

Questions? call toll free 1.800.957.9777  
[www.canadalife.com](http://www.canadalife.com)