

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:
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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

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): _____

Physician's signature _____ Telephone number: _____