

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity
Infant Apnea Monitor

Member's Name _____ Medicaid Certificate Number _____

Address _____

Parent/Guardian _____ Telephone Number _____

Member's Birthdate _____ Birth Weight _____ Gestational Age _____

Prescribing Practitioner _____

Address _____ 1 Medical Center Drive Morgantown, WV 26506 _____

Diagnosis relating to need of Apnea Monitor (Must be one of the conditions below):

- Sibling of SIDS
- Apparent life threatening event (ALTE)
- Infant with narcotic addict mother
- Infant with high risk cardiac disease
- Infant with tracheostomy
- Prematurity

Date of ALTE _____ Number of episodes _____

How documented _____

Hospital _____ West Virginia University Children's Hospital _____

Admission date _____ Discharge date _____

Estimated length of need/frequency of use:

- Short term (e.g., weaning from theophylline 1-2 weeks)
- One Month Two Months Three Months Six Months

Frequency of use _____

Apnea delay rate _____

Follow-up appointment scheduled for _____ with _____

DME Provider _____ Mountaineer Home Medical _____ Provider Number: 3810001835 _____ Telephone _____ 304-225-6290 _____

Address _____ 1063 Maple Drive, Suite 1B Morgantown, WV 26505 _____

Date of monitor placement _____

I, the undersigned, certify the above prescribed equipment is medically necessary for the indications certified above, and at the termination of the period of medical necessity, the monitor will be removed. If a renewal prescription is not issued, then the authorization for the monitor is cancelled and it is reasonable for the DME provider to remove the equipment.

Practitioner's Signature _____ Date Signed _____

I have read and understand that before the end of the estimated period of need, I must bring my infant to the prescribing practitioner's office or clinic so that he/she can determine how my infant is progressing and if there is further need for the monitor. Should I not comply with this regulation, then the monitor will no longer be prescribed and may be removed by the DME provider.

Parent/Guardian's Signature _____ Date Signed _____