CERTIFICATE OF MEDICAL NECESSITY - INFANT APNEA MONITOR

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 528 (8-2016)

Clear Fields

SECTION A - Certification Type/Date

Date	☐ Initial ☐ Revised ☐ Extension - Complete section C for extension request
Name	Patient ID

SECTION B - Information in this Section May Not Be Completed by the Supplier of the Items/Supplies

1.Diagnosis relating to need of apnea monitor (Check all that apply): ☐ Sibling of SIDS ☐ Prematurity ☐ Infant has periodic breathing with desaturation below 90% ☐ Infant has significant apnea of 20 seconds or longer ☐ Infant has mild to moderate apnea and desaturates below 90%		
2. Date of ALTE:	Number of episodes: ☐ 5-10 ☐ 11-20 ☐ Other	
How documented:		
Hospital:	Admission date:	Discharge date:
3. Estimated length of need: ☐ One Month ☐ Two Months ☐ Three Months ☐ Six Months Frequency:		Apnea delay rate:
Follow-up appointment date:	Follow-up physician:	

SECTION C - Must be completed to request an extension

Date of initial monitor placement:	Frequency of monitor use:
Date, frequency, and type of alarms in the past month:	
Date of last appointment:	Physician:
Date of next appointment:	Physician:
Please describe the conditons requiring extension:	

SECTION D - Narrative Description

Narrative description of all items, accessories and options ordered.

SECTION E - Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)