watermarkmedical™

Patient Name
Patient DOB

PLEASE REPLY BY FAX:
855-784-9383

URGENT – PLEASE REVIEW

To: _____ **From:** Medical Records Department

Fax: _____ **Pages:** _____ [Including cover]

Phone: _____ **Date:** _____

Based on your interpretation of the Home Sleep Test (HST) results for patient, _____, who came through their employer-provided Sleep Health and Wellness program, enclosed is a copy of your **final interpretation report, Final Assessment form,** and a **PAP therapy prescription (if applicable)**. We have contacted the patient to encourage a follow-up visit to review their Home Sleep Test results with you and their next steps.

Please Complete:

Final Assessment form along with the PAP Therapy prescription (if applicable) and fax to 855-784-9383.

Attached for your reference and completion is:

1. A copy of your final interpretation report (accessible through the Watermark Medical Portal)
2. PAP therapy prescription (also accessible through the Watermark Medical Portal)
3. Final Assessment form

Feel free to contact the patient directly about a follow-up appointment:
Patient:
DOB:
Phone: Alt:

Thank you in advance for your time. Please contact us at 866-875-9765 with any questions.

Regards,

Watermark Medical, Inc.

Employer Sleep Health and Wellness Program
Final Assessment Form

Patient:
DOB:
Study Start Date:

Hello

Thank you for being an integral part of your patient's sleep health and wellness. In order to track their trajectory in the program, we ask that you fill in the information below and fax to Watermark Medical at 855-784-9383. These data are crucial to the tracking of the patient's progress in their employer-provided Sleep Health and Wellness program.
Please complete this form after the patient's face-to-face visit where HST results, therapy options (if applicable), and/or other clinical recommendations are discussed.

	YES	NO
1. Did the patient show up for the review of their HST results?	☐	☐

2. Final Diagnosis (check all that apply):

- ☐ Obstructive Sleep Apnea
- ☐ Primary Snoring
- ☐ Primary Central Sleep Apnea
- ☐ Cheyne-Stokes Breathing
- ☐ Sleep Related Hypoxemia
- ☐ Other: _____

3. Therapy recommendation (check all that apply):

- ☐ Auto PAP
- ☐ Attended PAP titration
- ☐ Oral appliance
- ☐ Weight loss
- ☐ Positional therapy
- ☐ Other: _____

	YES	NO
4. Did the patient agree to seek therapy?	☐	☐
5. Was an attended diagnostic study recommended to further evaluate the patient's sleep? If yes, why? _____	☐	☐
6. Is the patient scheduled for a follow-up face-to-face appointment to review therapy use/efficacy and/or other diagnostic results?	☐	☐

Please fax completed forms to: 855-784-9383

The following additional documentation needs to be included and faxed to 855-784-9383:
❒Completed Final Assessment ❒Sleep Study

Dispensing Order

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City, State, Zip Code: _____

Payor Name: _____ Payor Phone: _____

Subscriber#: _____ Group#: _____

Estimated Length of Need (# of Months): _____ **Date of Service/Start Date: _____**

Diagnosis Codes (ICD-10): ❒OSA (G47.33) ❒Primary CSA (G47.31) ❒CSA (G47.37) ❒Other _____

CPAP/BILEVEL **DATE OF FACE TO FACE EVALUATION:_____**

1. **AHI or RDI:_____ DATE OF SLEEP STUDY:_____**

2. ❒ **Auto-PAP(E0601) settings at _____cmH20 low, _____cmH20 high**

   ❒ **CPAP (E0601) settings at _____cmH20 low, _____cmH20 high**

   ❒ **BiLevel (E0470) _____cmH20 IPAP, _____cmH20 EPAP**

   ❒ **AutoBilevel (E0470)_____Max IPAP, _____Min EPAP, _____ Max PS**

   ❒ **Bilevel ST-ASV (E0471)_____Max IPAP, _____Min EPAP, _____ Max PS**

   ❒ **HUMIDIFICATION:** ❒**HEATED(E0562)** ❒**Heated Tubing (A4604)** up to 1/3 MO or _____

3. **IF AHI/RDI BETWEEN 5 & 14, CHECK ALL CLINICALLY DOCUMENTED SYMPTOMS THAT APPLY:**
   ❒ EXCESSIVE DAYTIME SLEEPINESS ❒ IMPAIRED COGNITION ❒ MOOD DISORDER
   ❒ DOCUMENTED HYPERTENSION ❒ ISCHEMIC HEART DISEASE OR HISTORY OF STROKE

4. **CPAP / BiPAP ACCESSORY UTILIZATION REQUESTED:**
   ❒Mask ❒Headgear ❒Chinstrap
   ❒Nasal Cushion ❒Nasal Pillows
   ❒Water Chamber ❒Disposable Filter

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician's Signature: _____ **Date:** _____

Physician's Name: _____ **NPI#**: _____

FAX: This form & additional information to: 855-784-9383