

**CPAP/BiPAP
Purchase, With or
Without Humidifier**



PacificSource will convert your rental to a purchase approval when documentation is received on *patient compliance and treatment effectiveness*. Please submit this form with your claim for purchase.

REQUEST FOR PURCHASE			
Date of Request: _____			
Patient Name: _____		Patient ID Number: _____	
Patient Address: _____		City: _____	State: _____ Zip Code: _____
DOB: _____	HCPCS Codes: _____	Ordering Physician: _____	
REQUEST FOR PURCHASE			
Prior to approval of payment for purchase of a machine after the three-month rental period, the ordering physician must document: <ul style="list-style-type: none"> <input type="checkbox"/> Patient is compliant with treatment plan <input type="checkbox"/> Treatment is effective Physician Signature _____ Date _____			
CONTINUED RENTAL			
If continued rental rather than purchase is desired, please contact our Health Services Department for authorization at (541) 684-5584 or toll-free at (888) 691-8209. You may also fax your request to (541) 225-3625.			
Request Submitted by: _____			
Contact Person: _____		Date: _____	
Phone: _____		Fax: _____	

If your billing agent is not at your location, you may submit this completed form separately by faxing it to (541) 225-3632, or by mailing the form to:

PacificSource Health Plans
Attn: Claims Department
PO Box 7068
Springfield, OR 97475

Coverage is dependent upon available contract benefits for services requested.