Unity health network
Sleep Therapy

Patient Name & Account #:

We are contacting you for your 90 day CPAP therapy follow up. Please call us at the number on this letter or return this questionnaire. This compliance letter is required every 90 days by your insurance company.

1. Are you currently seeing the same doctor that ordered your CPAP machine? YES____ NO____
    a. If not, please indicate current doctor: _____
2. How many HOURS a night do you use your machine: _____
3. How many NIGHTS per week are you using your machine: _____
4. Are you having any Daytime Sleepiness: YES____ NO____
5. Are you experiencing Headaches: YES____ NO____
6. Is your insurance and residence still the same: YES____ NO____
    a. If no, please provide updated information:
    _____
    _____
7. If you are having problems with your machine, pressure, or supplies please call me at 330-572-1011, ext. 178 to make your appointment with our staff therapist.
8. If you are having daytime sleepiness or any other problems with sleep, and if it is interrupting your day, please contact your doctor. Adjustments may need to be made to your CPAP therapy.

SUPPLIES:
Please indicate what supplies you are in need of at this time:

90 Day Supplies:
Cushions/Pillows: YES____ NO____, Size:_____
Filters: YES____ NO____
Tubing: Standard _____ OR Heated _____
Mask: YES____ NO____, If you have more than one mask, which do you wish to be sent: **PLEASE INDICATE WHICH MASK YOU ARE CURRENTLY USING. THANK YOU**

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180 Day Supplies:
Headgear: Yes_____NO:_____ (only if this is separate from your mask)
Water Chamber: Yes: _____No: _____
Chin Strap: Yes: _____ No: _____ (separate from full face mask)

See next page for guideline on allowable supply amounts per your Insurance

Patient Comments:
_____
_____

BILLING CONCERNS: If you have a delinquent balance, call 1-330-923-6606 to set up payment arrangements before ordering CPAP Supplies. It is your responsibility to contact your insurance company regarding your cost of supplies. If deductibles are not met, supply costs will be applied to your

deductible and insurance will pay according to your co-insurance. If deductible is not met, you are responsible for co-insurance costs until your deductible and out of pockets have been met. Our financial policy states supplies will not be sent if you have a balance over $200.00.

Our office will be contacting you every 90 days to follow up with your CPAP therapy and supplies. Thank you for your time.

Patient Care Coordinator, Unity Health Network, LLC

701 White Pond Dr., Akron, OH 44320 330-572-1011 option #6

Please Note: Any opened supplies cannot be returned or exchanged!

INSURANCE GUIDELINES ON SUPPLY REPLENISHMENT

A7030 – Full Face Mask	**1 per 3 months**
A7031 – Full Face Cushions	**1 per month**
A7034 – Nasal Pillow Mask	**1 per 3 months**
A7032 – Nasal Mask Cushions	**2 per month**
A7033 – Replacement Nasal Pillows	**2 per month**
A7035 – Headgear	**1 per 6 months**
A7036 – Chinstrap	**1 per 6 months**
A7037 – Tubing	**1 per 3 months**
A4604 – Heated Tubing	**1 per 3 months**
A7038 – Disposable Filter	**2 per month**
A7039 – Non-disposable Filter	**1 per 6 months**
A7046 – Water Chamber	**1 per 6 months**