APPENDIX H
CERTIFICATION FOR APNEA/BRADYCARDIA MONITOR

Alliant GMCF PA/UM
Department
PO Box 105329
Atlanta, GA 30346

Member Full Name: _____

Member Medicaid #: _____ CANNOT BE MOTHERS #

Date of Birth: _____

Member's Diagnosis (please use check mark in appropriate box)
***Must* be one of the following OR prior approval will be denied:**

- ☐ APNEA
- ☐ BRADYCARDIA
- ☐ REFLUX with apnea
- ☐ SIDS SIBLING (brother or sister)

Length of time monitor will be needed: _____

NOTE: ADDITIONAL MEDICAL JUSTIFICATION IS REQUIRED FOR A MEMBER 10 MONTHS OF AGE OR OLDER **OR RENTAL EXCEEDING 4 MONTHS**

Does member have a tracheostomy: ☐ Yes ☐ No

If member does not have a tracheostomy:

- A separate letter from the M.D. is required to justify medical necessity for continued use of monitor beyond 10 months of age OR use beyond a 4 month period.
- A copy of an actual monitory strip, readout, or download is required documenting an episode(s) of apnea or bradycardia within the past three months.

I CERTIFY THAT THIS ELECTRIC APNEA MONITOR IS MEDICALLY NECESSARY:
Physician Signature _____ Date _____
Printed Name of MD _____
MD Address _____

DATE STAMPS ARE NOT ACCEPTABLE