



Provider Set-Up Form for PAP Therapy Sleep Management Program

Fax # (866) 501-4668

Date of Set-Up: _____

Set-Up Performed at: _____

Patient and Physician Information

Patient Name	D.O.B.	Physician Name	Physician Phone
Address			
Patient Primary Contact #		Patient Email Address	
Patient Secondary Contact #		Patient Emergency Contact Name & Phone	

Equipment Provided

PAP Devices and Settings

<input type="checkbox"/> CPAP: EPAP _____ cmH2O <input type="checkbox"/> Auto PAP: Min _____ cmH2O Max _____ cmH2O <input type="checkbox"/> Bi-Level: EPAP _____ cmH2O / IPAP _____ cmH2O <input type="checkbox"/> Auto Bi-Level: Min EPAP _____ cmH2O Max IPAP _____ cmH2O <input type="checkbox"/> Bi-Level ST: IPAP Min _____ cmH2O Max _____ cmH2O RR: _____ <input type="checkbox"/> Auto SV: IPAP Min _____ cmH2O Max _____ cmH2O EPAP _____ cmH2O Rate: <input type="checkbox"/> Off <input type="checkbox"/> Auto <input type="checkbox"/> _____ <i>Any other settings appropriate (Flex, Ramp, etc.)</i>	<input type="checkbox"/> Initial Unit <input type="checkbox"/> Replacement Unit Make & Model: Serial Number: Humidifier: <input type="checkbox"/> Heated <input type="checkbox"/> Cool/Passover Mask: <input type="checkbox"/> Nasal Pillows <input type="checkbox"/> Nasal <input type="checkbox"/> Full Mask Type/Name: Mask Size: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> Other: _____
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Compliance Measurement <input type="checkbox"/> Card <input type="checkbox"/> Modem/Wireless <input type="checkbox"/> USB	Wireless ID #	Patient Email Address Entered in Monitoring Site:
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SMS Tagged as "Primary Care Physician" or "Sleep Doctor" in Monitoring Site and Granted Authorized User Status
 Yes No Unknown

Therapy Adherence Agreement:
 By signing below, I am indicating my agreement to be an active participant in the Cigna Sleep Management Therapy Adherence Program. I understand and agree that my PAP therapy data can be shared with my treating physician, my PAP provider, and CareCentrix to assist with my PAP therapy and adherence. I also agree that I may be contacted by phone, text or email at the phone numbers and email address listed above, including but not limited to, for purposes of helping ensure I am receiving the appropriate support for my PAP therapy adherence. I understand that adherence is defined as using my prescribed equipment a minimum of 70% of nights for an average of 4 hours per night. Unless otherwise noted below, I also give CareCentrix and their staff permission to leave detailed messages regarding my PAP therapy at the phone numbers and email address documented above.
 I DO NOT give CareCentrix permission to leave detailed messages regarding my sleep therapy.

Additional comments for Cigna Therapy Adherence Team:

Patient Signature	Date	
Provider Name	Signature Company Representative	Date