Island Home Medical
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Welcome to Island Home Medical's a Better Night's Sleep Program. We are here to work with you throughout your Sleep Therapy. Our goal is to help you achieve comfort and compliance with your PAP equipment to get the restful sleep your body requires.

Your physician and insurance provider will require follow-up and usage documentation to continue the payment coverage of the PAP equipment that you have been provided by Respiratory Home Services. Much of this will be done through your calls relaying your concerns to us, or by us doing phone follow-ups with you. You have been given a data card reader. Your doctor will require a download from the PAP device for your follow-up visit to document your usage, and the efficacy of your Sleep Therapy Program.

It is extremely important that you return our follow up calls, letters, and compliance download requests. Failure to do so may result in your insurance denying payment and the PAP equipment becoming your financial responsibility.

IMPORTANT INFORMATION ABOUT YOUR INSURANCE COVERAGE

Your insurance company has agreed to pay their portion of approved monthly charges (not including your copay/deductible) *for three months only*. Your physician must then review that data from your PAP device during an office visit with you.

Continued coverage of a PAP device beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, your treating physician must conduct a clinical re-evaluation and document that you are benefiting from PAP sleep therapy.

The Download report must show that you use the device 70% of the nights for a minimum of 4 hours a night during any continuous 30 day period during your first three months of sleep therapy.

Your insurance is strict regarding this policy and the first 90 days of usage data. If you are unsuccessful in the first 90 days you will have options for improving compliance, and the option to rent or purchase the equipment privately, or return the equipment to us.

I acknowledge and understand my obligation to follow-up with Respiratory Home Services and my physician. I also understand that failure to meet this re-certification requirement may result in my financial responsibility for payment of this equipment beyond the initial 90 days.

Signature _____ Date _____