

Instructions

1. Residents of Saskatchewan, Manitoba and Ontario: For CPAP machines, you must apply for coverage through your provincial health program before submitting a claim or estimate to GMS.
2. Complete section A and have your physician complete sections B, C and D. For supplies only, complete sections A, B and D.
3. We recommend submitting an estimate to confirm eligibility and coverage before purchasing a CPAP machine.
4. Submit this request form with a claim form and include all receipts/estimates. We recommend keeping copies for your records.
5. Claims can be submitted by logging into your My GMS account and sending them to us online or by mailing to: Claims, Group Medical Services, 2055 Albert Street, PO Box 1949 Regina, SK S4P 0E3

A. Personal Information

First Name	Last Name	GMS ID Number
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B. Medical Diagnosis (to be completed by referring physician)

a. What sleep study did the patient participate in? *(Please attach a copy of the sleep study diagnostic report and any titration)*
 Level 1 or Level 3

b. Which diagnosis is indicated with the sleep study?
 Mild OSA Moderate to Severe OSA Other. Please specify: _____

c. If mild OSA, please advise if:
 patient has other medical conditions/comorbidities. Please specify:

patient works in a safety-sensitive occupation. Please specify:

C. Machine Request (to be completed by referring physician)

Is this an initial or replacement CPAP machine? *(please only select one)*

C1. Initial CPAP machine

What type of device are you prescribing the patient?

C2. Replacement CPAP machine

a. What was the patient's previous device? _____

b. When did the patient get the previous device? *(DD/MM/YYYY)* _____

c. What is the patient's new device? _____

d. Please advise why the patient needs a new machine/reason why they are getting a different type of machine.

D. Declaration (to be completed by referring physician)

I declare that the information provided is true, correct and complete.

Physician Name	Physician Registration Number
Physician Designation	Phone Number () -
Referring Physician's Signature X	Date <i>(DD/MM/YYYY)</i>