Statement of Pulmonary Arterial Hypertension Diagnosis

Patient name__________________________________________________

Physician name_________________________________________________

Diagnosis (Please check one - If secondary pulmonary hypertension, identify the underlying cause):
  ☐ Primary pulmonary hypertension
  ☐ Secondary pulmonary hypertension—Medicare-covered
  ☐ Connective tissue disease (Please specify, e.g., scleroderma, lupus)
  ☐ Thromboembolic disease of the pulmonary arteries
  ☐ HIV infection
  ☐ Anorectic drug therapy
  ☐ Congenital heart disease—ASD or VSD
  ☐ Cirrhosis
  ☐ Other____________________________

Secondary pulmonary hypertension—non-Medicare covered
  ☐ Sleep apnea
  ☐ Cardiomyopathy
  ☐ Congenital heart disease—other than ASD or VSD
  ☐ COPD
  ☐ Pulmonary fibrosis
  ☐ Emphysema
  ☐ Interstitial lung disease
  ☐ Sarcoidosis of the lung
  ☐ Left-sided valvular disease
  ☐ Other_____________________________

Physician’s signature_______________________________________Date____________________

Fax completed form to 800.711.3526

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