Physician's Prescription and Letter of Medical Necessity

Fax: 1-888- 816-5060
Phone: (760) 779-1444

Please Provide: ☐ Demographics ☐ Sleep Study/Testing ☐ Insurance Card ☐ Medical History/Physical (if) Available

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Gender: _____

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Ins. Co.: _____ Subscriber #: _____ Group #: _____

Primary Ins. Phone: _____

SLEEP DIAGNOSTICS

☐ G0399/95806 Home Sleep Test (Type III)
☐ G0399/95806 Therapy Titration with Oral Appliance (OAT)
☐ 95810 Polysomnography (All Night Baseline Sleep Study)
☐ 95805 Multiple Sleep Latency Test (MSLT)
☐ 95811 Polysomnography with CPAP/BIPAP Titration
☐ Other: _____

INTERPRETATING PHYSICIAN

☐ Pro Sleep Care's Qualified Interp. Physician
☐ Other (Please specify): _____

☐ Obstructive Sleep Apnea G47.33
☐ Unspecified Sleep Apnea G47.30
☐ Central Sleep Apnea G47.31
☐ PLMS G47.61
☐ Hypersomnia Unspecified G47.10
☐ Other Hypersomnia G47.19
☐ Morbid Obesity E66.01
☐ Other Sleep Disorders G47.8
☐ Restless Legs Syndrome G28.81
☐ Excessive Daytime Sleepiness
☐ Snoring
☐ Hypertension
☐ Diabetes

Rx

DME SERVICE:

☐ E0601 Auto CPAP/CPAP (with heated humidifier, mask to fit & supplies)

☐ E0470 BiPAP (with heated humidifier, mask to fit & supplies)

☐ A7030-A70399 Replacement Supplies related to PAP Therapy

☐ **Length of Need: 99 / Lifetime or Other** _____

LETTER OF MEDICAL NECESSITY

The above referenced patient has an absolute ***Medical Necessity*** for the item(s) listed above. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and medically necessary with reference to the standards of medical practice for this patient's condition. The duration of the equipment/supplies will be lifetime unless otherwise indicated here: _____.

In addition to reviewing the ***Sleep Study*** the patient has co-morbidities marked below, which require the necessary prescribed items above.

☐ Hypertension ☐ Pulmonary hypertension ☐ Impaired cognition or mood disorders ☐ Ischemic heart disease or history of stroke
☐ Excessive daytime sleepiness with an Epworth score of 10 or greater

Physician Name: _____ NPI: _____

Phone: _____ Fax: _____ Contact: _____

PHYSICIAN SIGNATURE: X_____ **DATE**: _____