



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

- | | |
|---|--|
| <input type="checkbox"/> G0399/95806 Home Sleep Test (Type III) | <input type="checkbox"/> G0399/95806 Therapy Titration with Oral Appliance (OAT) |
| <input type="checkbox"/> 95810 Polysomnography (All Night Baseline Sleep Study) | <input type="checkbox"/> 95805 Multiple Sleep Latency Test (MSLT) |
| <input type="checkbox"/> 95811 Polysomnography with CPAP/BIPAP Titration | <input type="checkbox"/> Other: _____ |

REFERRING PHYSICIAN

 Other (Please specify): _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Obstructive Sleep Apnea G47.33 | <input type="checkbox"/> Unspecified Sleep Apnea G47.30 | <input type="checkbox"/> Central Sleep Apnea G47.31 |
| <input type="checkbox"/> PLMS G47.61 | <input type="checkbox"/> Hypersomnia Unspecified G47.10 | <input type="checkbox"/> Other Hypersomnia G47.19 |
| <input type="checkbox"/> Morbid Obesity E66.01 | <input type="checkbox"/> Other Sleep Disorders G47.8 | <input type="checkbox"/> Restless Legs Syndrome G28.81 |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> Hypertension |
| | | <input type="checkbox"/> Diabetes |

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:** _____