Phone: (760) 779-1444
Toll Free: (888) 806-3535
Fax: (888) 816-5060
Info@ProSleepCare.com

SERVICE REQUEST FORM AND STATEMENT OF MEDICAL NECESSITY

Please fax this form along with a copy of patient's progress notes and insurance card to: **(888) 816-5060**

Patient Name: ______________________ DOB: ____ /____ / Gender:____ Height:_____ Weight:_____

Address: ______________________ City: ____________ State: __________ Zip: ___________

Best Contact Number: (_____) ______________ Alternate No. If Any: (_____) ______________

Primary Insurance Name: ______________________ Insurance ID#: ______________________

REFERRING PHYSICIAN INFORMATION

Physician Name: Physician NPI #: ______________________

Office Contact: ____________ Phone: (______) ____________ Fax: (_____) ____________

PRESCRIBED SERVICE (S)

IN LAB TESTING

- ❑ **95810 PSG –POLYSOMNOGRAPHY, DIAGNOSTIC ONLY**
- ❑ **95811 SPLIT NIGHT –POLYSOMNOGRAPHY WITH CPAP/BIPAP TITRATION**
- ❑ **95811 2nd NIGHT STUDY – DEDICATED TO CPAP/BIPAP TITRATION**
- ❑ **95805 MSLT- MULTIPLE SLEEP LATENCY TEST**

HOME SLEEP TESTING

- ❑ **G0399/95806-UNATTENDED HOME SLEEP TESTING (TYPE III HST)**
- ❑ **G0399/95806-UNATTENDED HOME SLEEP TESTING (TYPE III HST) w. Oral Appliance (Treatment Efficacy Testing)**

INTERPRETING PHYSICIAN NAME

- ❑ PRO SLEEP CARE'S QUALIFIED INTERPRETING PHYSICIAN
- ❑ OTHER (PLEASE SPECIFY):______________________

PATIENT'S HISTORY & SYMPTOMS (Please forward us a copy of patient's H&P or progress note to indicate the following)

- ❑ WITNESSED APNEAS
- ❑ LOUD, HEAVY SNORING OFTEN INTERRUPTED BY SILENCE & GASPS
- ❑ EXCESSIVE DAYTIME SLEEPINESS OR FATIGUE
- ❑ OBESITY/LARGE NECK
- ❑ HEART DISEASE
- ❑ STROKE
- ❑ HYPERTENSION
- ❑ OTHER (PLEASE SPECIFY): ______________________

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY FOR THE REQUESTED TESTING

- ❑ G47.30 - UNSPECIFIED SLEEP APNEA
- ❑ G47.33 - OBSTRUCTIVE SLEEP APNEA
- ❑ G47.31 - PRIMARY CENTRAL SLEEP APNEA
- ❑ G47.419 - NARCOLEPSY, WITHOUT CATAPLEXY
- ❑ G47.411 - NARCOLEPSY, WITH CATAPLEXY
- ❑ G47.10 - HYPERSOMNIA, UNSPECIFIED
- ❑ E66.01 - MORBID OBESITY
- ❑ G47.8 - OTHER SLEEP DISORDERS
- ❑ G47.00 - INSOMNIA WITH SLEEP APNEA, UNSPECIFIED
- ❑ G47.61 - PERIODIC LEG MOVEMENT DISORDER
- ❑ G25.81 - RESTLESS LEGS SYNDROME
- ❑ G47.36 - SLEEP-RELATED HYPERVENTILATION IN CONDITIONS CLASSIFIED ELSEWHERE
- ❑ F51.8 - OTHER SLEEP DISORDERS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION
- ❑ G47.19 - OTHER HYPERSOMNIA

PHYSICIAN SIGNATURE: ______________________ **DATE:** ____________

By signing above, I certify that the above prescribed services(s) is/are medically indicated and in my opinion is/are reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.