



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

[Sleep@prosleepcare.info](mailto:Sleep@prosleepcare.info)

### SERVICE REQUEST FORM AND STATEMENT OF MEDICAL NECESSITY

Please fax this form with a copy of patient's insurance card & clinical notes to **(888) 816-5060**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Best Contact Number: (\_\_\_\_) \_\_\_\_\_ DAY/CELL: (\_\_\_\_) \_\_\_\_\_  
 Primary Insurance Name: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION**

Physician Name: \_\_\_\_\_ Physician NPI#: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

### PERSCRIBED SERVICE(S)

**IN LAB TESTING:**

- 95810 PSG –POLYSOMNOGRAPHY, DIAGNOSTIC ONLY
- 95811 SPLIT NIGHT –POLYSOMNOGRAPHY WITH CPAP/BIPAP TITRATION
- 95811 2 ND 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)

**INTERPRETATING 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
- OBESTIY/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, W/OUT CATAPLEXY
- G47.411 – NARCOLEPSY, WITH CATAPLEXY
- G47.10 – HYPERSOMNIA, UNSPECIFIED
- G47.19 – OTHER HYPERSOMNIA
- E66.01 - MORBID OBESITY
- G47.8 – OTHER SLEEP DIDORDERS
- G47.00 – INSOMNIA W/ SLEEP APNEA,
- G47.61 – PERIODIC LEG MOVEMENT DISORDER
- G25.81 – RESTLESS LEGS SYNDROME
- G47.36 – SLEEP-RELATED HYPOVENTILATION IN CINDITIONS CLASSIFIED ELSEWHERE
- F51.8 – OTHER SLEEP DISORDERSNOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION

**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.*