Physician's Prescription & Statement of Medical Necessity
For Diagnosis of Sleep Disorders

Please fax to 866-427-8504 Phone: 866-937-6692 or 919-570-9715

PATIENT: ______ SOC. SEC#: ______ DOB: ______ ☐ M ☐ F

ADDRESS: ______ CITY: ______ STATE: ____ ZIP: ______

HOME PHONE: ______ WORK PHONE: ______ CELLPHONE: ______

EMAIL ADDRESS: ______

INSURANCE: ______ ID: ______ GROUP: ______

POLICY HOLDER'S NAME AND DOB: ______

2ND INSURANCE: ______ ID: ______ GROUP: ______

POLICY HOLDER'S NAME AND DOB: ______

PLEASE PROVIDE A COPY OF THE PATIENT'S INSURANCE CARD AND CLINICAL NOTES

EPWORTH SCORE: ______ HEIGHT: ______ Inches WEIGHT: ______ Lbs.

NECK CIRCUMFERENCE: ______ Inches BMI: ______

REQUESTED SERVICE/CPT CODE	**DIAGNOSTIC PANEL**	**CO-MORBID CONDITIONS**
☐ Baseline PSG 95810	☐ G47.33 Obstructive Sleep Apnea	☐ Morbid Obesity
☐ Split Night Study 95811	☐ G47.31 Central Sleep Apnea	☐ Severe pulmonary disease
☐ CPAP Titration 95811		☐ Congestive Heart Failure
☐ BILEVEL Titration 95811	☐ Other ______	☐ History of stroke
☐ MWT 95805 (NPSG and MWT)		☐ Pulmonary hypertension
☐ MSLT 95805 (NPSG and MSLT)		☐ Other ______
☐ Other		

INDIVIDUAL ORDERS OR SPECIAL NEEDS OF THE PATIENT: ______

I certify that the above prescribed test(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. The above-named patient has an absolute medical necessity for the item(s) listed, based on the suspected diagnosis. <u>A second order will be sent for signature if the patient requires a separate test for a titration study.</u>

PHYSICIAN'S SIGNATURE: ______ **DATE:** ______ **TIME:** ______

SELECT INTERPRETING PHYSICIAN: ☐ No Preference ☐ Dr. Alfred DeMaria
☐ Dr. Douglas Lee ☐ Dr. Kevin O'Neil ☐ Dr. Michael Parker

Consult: ☐ Check here to have patient who tests positive referred to interpreting physician for follow up. SleepMed will send the referral.
DME: ☐ Check here if you would like SleepMed Therapy Services to handle DME set up if recommended.

REFERRING PHYSICIAN: ______ NPI: ______

ADDRESS: ______

PHONE: ______ FAX: ______ FORM COMPLETED BY: ______