phone 562.420.7353
fax 562.372.3698
email thesleepapneagirl@gmail.com

Physician's Prescription & Statement of Medical Necessity

Please fax this form along with a copy of patient's H&P/Progress Note and Insurance Card

Patient Name:______________________________ DOB:__________ SS#:________________

Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Email: ______________________

Height: __________ Weight: __________ BMI: __________ Neck Size: __________

Dx:

- ❒ Sleep Apnea
- ❒ Central Sleep Apnea
- ❒ HTN
- ❒ Obesity
- ❒ COPD
- ❒ Hypoxemia
- ❒ Excessive Daytime Sleepiness
- ❒ Other: ______________________
- ❒ Insomnia
- ❒ Ischemic Heart Disease
- ❒ Mood Disorders
- ❒ Impaired Cognition
- ❒ Narcolepsy
- ❒ Restless Leg Syndrome
- ❒ PLMD
- ❒ Diabetes
- ❒ CHF

Please provide: Copy of Insurance Card, Demographics, & History/Physical

Sleep Diagnostic Services:

Service	Code / Description
______Polysomnography (All night baseline sleep study)	(CPT-95810) Diagnostic
______CPAP Titration	(CPT-95811) CPAP
______PSG w/ BIPAP Device (In place of CPAP)	(CPT-95811) Diagnostic w/ BIPAP pressure determination
______PSG w/ Mandibular Device	(CPT-95811) Diagnostic
______PSG w/ Mandibular Device/CPAP/BIPAP	(CPT-95811) BiLevel
______ASV/VPAP Titration	(CPT-95811) ASV/VPAP Titration
______BiLevel Titration	(CPT-95811) BiLevel
______Multiple Sleep Latency Test	(CPT-95805) Day Study
______Polysomnography w/ Titration (50/50 Split Study)	(CPT-95811) Baseline / Titration
______CPAP Interfaces Masks Nasal or Full Face	HCPCS A7034,A7030,A7035,A7033
______Unattended Home Sleep Testing (HST) 2 Nights Min.	(CPT-95806) Portable Home Testing
______Sleep Consultation 94660	Consultation with Board Certified Sleep Medicine MD
______Non Restorative Sleep	

Clinical Impression/Diagnosis/Reason for Study:

- ❒ Witnessed Apnea
- ❒ Sleep Walking
- ❒ HTN
- ❒ Morning Headaches
- ❒ Other:______________
- ❒ Sleep Talking
- ❒ Habitual Snoring
- ❒ Excessive Daytime Sleepiness
- ❒ OSA
- ❒ Insomnia
- ❒ Ischemic Heart Disease
- ❒ Mood Disorders
- ❒ CSA
- ❒ Impaired Cognition
- ❒ Narcolepsy
- ❒ Restless Leg Syndrome
- ❒ PLMD

Oxygen Therapy | **Overnight Oximetry Testing**

❒ Home O2 at ______ LPM # of Month(s) _____ Frequency: ❒ 24 Hrs ❒ PRN ❒ Nocturnal ❒ Via nasal cannula ❒ Via mask

Via: ❒ E1390 Stationary Concentrator ❒ E1392 Portable Concentrator ❒ **Overnight Oximetry Test**

Test Results Date: ___________ PO2 ______% SAT on Room Air _____ Test Results Taken At: ❒ Rest ❒ Exercise ❒ Sleep

Referring Physician:______________________________

Address: ______________________________

Contact:______________ Phone:______________ Fax:______________

License #: ______________ DEA: ______________ NPI: ______________

Physician's Signature: ______________________________ **Date:** ____________

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