



**ADVANCED
SLEEP MEDICINE SERVICES, INC.**

"Better Sleep for a Brighter Tomorrow"

SERVICE REQUEST FORM

(*PLEASE FILL OUT EVERY BOX THAT APPLIES TO YOUR PATIENT TO AVOID ANY DELAY

***PATIENT INFORMATION:**

PATIENT NAME: _____ DOB: ____/____/____ GENDER: M F

ADDRESS _____ CITY _____ STATE _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____

SSN: ____/____/____ INS. Co: _____

***REFERRING PHYSICIAN INFORMATION:**

NAME: _____, M.D. TEL: _____ FAX: _____

PHYSICIAN UPIN #: _____ OFFICE CONTACT PERSON: _____

***SERVICE REQUESTED**

(PLEASE CHECK):

- BASELINE POLYSOMNOGRAPHY
CPT CODE: 95810
- SECOND NIGHT CPAP TITRATION
CPT CODE: 95811
- 50/50 POLYSOMNOGRAPHY/CPAP
SPLIT STUDY
CPT CODE: 95811
- MULTIPLE SLEEP LATENCY TEST (MSLT)
CPT CODE: 95805
- OTHER (PLEASE SPECIFY): _____

DEVICE REQUESTED (IF KNOWN):

(PLEASE CHECK):

- CPAP DEVICE SET-UP
HCPC CODE: E0601

PRESSURE SETTING: CM H2O
MASK SIZE
HUMIDIFIER? _____ Yes _____ No
- BI-LEVEL DEVICE SET-UP
HCPC CODE: E0470

PRESSURE SETTING: IPAP.....CM H2O
EPAP.....CM H2O
MASK SIZE:
HUMIDIFIER? _____ Yes _____ No

***INTERPRETATION OF RESULTS FOR SLEEP STUDY TO BE DONE BY**

(PLEASE CHECK):

- S. K. MOSTAFAVI, M.D.
- OTHER (PLEASE SPECIFY): _____

Physician / Referral Coordinator's Signature: _____ Date: _____

PLEASE FAX THIS FORM TOGETHER WITH A COPY OF THE
PATIENT'S INSURANCE CARD AND THE FACE SHEET TO
TOLL FREE (877) 855-6227 OR (310) 479-0330