



SERVICE REQUEST FORM AND STATEMENT OF MEDICAL NECESSITY

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: M F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

PRESCRIBED SERVICE(S)

(Please Check)

- 50/50 SPLIT STUDY (POLYSOMNOGRAPHY WITH CPAP/ BIPAP TITRATION) **CPT: 95811**
- PSG (POLYSOMNOGRAPHY) **CPT: 95810**
- 2ND NIGHT STUDY DEDICATED TO CPAP/ BIPAP TITRATION **CPT: 95811**
- MSLT (MULTIPLE SLEEP LATENCY TEST) **CPT: 95805**
- UNATTENDED HOME PORTABLE MONITORING, AND IF INDICATED, FOLLOWED BY COMPREHENSIVE IN-LAB SLEEP STUDY **CPT: 95806 / G0399 FOLLOWED BY 95811**
- OTHER (PLEASE SPECIFY): _____

INTERPRETATION BY

(Please Check)

- ASMS Qualified Sleep Physician
- Other (Please Specify Name): _____

NOTE: For Medicare patients, interpreting physicians must meet Medicare required qualifications.

PLEASE NOTE: Based on Medicare guidelines, sleep study testing is not covered for snoring without other related symptoms.

DX CODES DESCRIPTION

- 278.01 MORBID OBESITY
- 327.51 PERIODIC LIMB MOVEMENT DISORDER
- 347.00 NARCOLEPSY
- 780.09 ALTERATION OF CONSCIOUSNESS OTHER
- 780.51 INSOMNIA WITH SLEEP APNEA, UNSPECIFIED
- 780.53 HYPERSOMNIA WITH SLEEP APNEA, UNSPECIFIED
- 780.54 HYPERSOMNIA, UNSPECIFIED
- 780.55 DISRUPTION OF 24 HOUR SLEEP WAKE CYCLE, UNSPECIFIED
- 780.56 DYSFUNCTIONS ASSOCIATED WITH SLEEP STAGES OR AROUSAL
- 780.57 UNSPECIFIED SLEEP APNEA
- 780.58 RESTLESS LEG SYNDROME/RELATED MOVEMENT UNSPECIFIED
- 780.59 OTHER SLEEP DISTURBANCES
- 799.02 HYPOXEMIA

HISTORY & SYMPTOMS

(Please Check)

- HISTORY OF WITNESSED APNEAS
- LOUD, HEAVY SNORING OFTEN INTERRUPTED BY SILENCE & GASPS
- HISTORY OF EXCESSIVE DAYTIME SLEEPINESS (EDS)
- OBESITY
- HEART DISEASE
- STROKE
- HYPERTENSION
- OTHER (PLEASE SPECIFY): _____

REFERRING PHYSICIAN INFORMATION

I certify that the above service(s) prescribed by me is/are medically indicated and in my opinion is/are reasonable and necessary with reference to all professionally recognized medical standards and treatment of this patient's condition.

Name: _____ TEL: (____) _____ FAX: (____) _____

Physician Signature: _____ Date: _____

PLEASE FAX THIS SIGNED FORM ALONG WITH A COPY OF THE PATIENT'S INSURANCE CARD TO (877) 855-6227