Advanced Sleep Medicine Services, Inc.
The Sleep Experts ®
www.sleepdr.com

Service Request Form

Tel: (877) 775-3377
Fax: (877) 855-6227
Email: orders@sleepdr.com

Patient Name: _____ DOB: ___/___/___ Gender: ☐ M ☐ F Height: _____ Weight: _____

Address: _____ City: _____ State: _____ ZIP: _____

Patient Email: _____ Mobile: (_____) _____ Alternate: (_____) _____

History & Symptoms:

- ☐ History of excessive daytime sleepiness (EDS)
- ☐ Heart Disease
- ☐ Stroke/TIA
- ☐ Hypertension
- ☐ History of witnessed apneas
- ☐ Loud, heavy snoring, often interrupted by gasps
- ☐ Central sleep apnea
- ☐ Parasomnias
- ☐ Bruxism (teeth grinding)
- ☐ Periodic leg movements (PLMs)
- ☐ Cataplexy
- ☐ Obesity, BMI: _____
- ☐ Oxygen use at night at liters/min: _____
- ☐ Epworth Sleepiness Scale score: _____
- ☐ Neck Size: _____
- ☐ Other: _____

Home Sleep Test (HST)

☐ **Home Sleep Test** (HST) *(95806 or G0399)* ☐ **Home Sleep Test** (HST) with **Oral Appliance** *(95806 or G0399)*

Sleep study interpretation by:

☐ Advanced Sleep Medicine Services, Inc. ☐ Other physician: _____

If the interpreting physician is not specified, or not boarded for Medicare interpretation, an Advanced Sleep Medicine Services, Inc. qualified physician will interpret the sleep study. If you select a non-Advanced Sleep Medicine Services, Inc. physician, s/he may bill separately for the sleep study interpretation.

PAP Therapy

1. Select a Device:

- ☐ CPAP (E0601) @ _____ cm/H20
- ☐ APAP (E0601) @ default settings 4-20 cm/H20
- ☐ Bi-level or BiPAP (E0470) @ ___/___ cm/H20
- ☐ ASV (E0471) EPAP min/max: ___ / ___
  IPAP min/max: ___ / ___
  PS min/max: ___ / ___ Rate:
- ☐ Other: _____

2. Select:

- ☐ Heated Humidifier (E0562)

3. Select Supplies :

- ☐ **All supplies, as needed**, or select individually:
- ☐ Humidifier Chamber (A7046) (1 per 6 months)
- ☐ Nasal Mask or Pillows Mask (A7034) (1 per 3 months)
- ☐ Nasal Mask Cushion Replacement (A7032) (1 per 3 months)
- ☐ Nasal Mask Pillow Replacement (A7033) (1 per 3 months)
- ☐ Full-face Mask (A7030) (1 per 3 months)
- ☐ Full Face Mask Cushion Replacement (A7031) (1 per month)
- ☐ Headgear (A7035) (1 per 6 months)
- ☐ Chinstrap (A7036) (1 per 6 months)
- ☐ Disposable Filters (A7038) (2 per month)
- ☐ Tubing, 6ft Std. (A7037) (1 per 3 months)
- ☐ Heated Tubing (A4604) (1 per 3 months)
- ☐ Other: _____

4. Select Diagnosis:

- ☐ G47.33 Obstructive sleep apnea
- ☐ G47.00 Insomnia w/sleep apnea, unspecified
- ☐ G47.10 Hypersomnia, unspecified
- ☐ G47.30 Sleep apnea, unspecified
- ☐ G47.31 Primary central sleep apnea
- ☐ G47.61 Periodic leg movement disorder
- ☐ G47.8 Other sleep disorder
- ☐ F51.8 Other sleep disorder not due to a substance or known physiological condition

5. Select Duration of Need:

- ☐ 99, Lifetime- for ongoing supplies as needed
- ☐ Other: _____

☐ Consultation with Physician *(PPO, Medicare or cash pay only)*

We will refer the patient to a boarded sleep specialist in the patient's area. The physician will bill separately for the consultation. For HMO or similar insurance, please refer the patient to their medical group or Primary Care Physician.

Referring Physician Information

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

Physician Name: _____

Phone: (_____)_____ Fax: (_____)_____

NPI: _____ Office Contact Person: _____

Office Address: _____

_____

Physician Signature _____ Date: _____

*Physician must be PECOS certified to refer Medicare patients.

Please fax this signed form with **H&P or progress notes and insurance card** to **(877) 855-6227** or email **orders@sleepdr.com**