



Service Request Form

Patient Name: _____ DOB: ___/___/___ Gender: M F Height: _____ Weight: _____
Address: _____ City: _____ State: _____ ZIP: _____
Patient Email: _____ Mobile: (____) _____ Alternate: (____) _____

History & Symptoms:

- | | | |
|--|--|---|
| <input type="checkbox"/> History of excessive daytime sleepiness (EDS) | <input type="checkbox"/> Loud, heavy snoring, often interrupted by gasps | <input type="checkbox"/> Obesity, BMI: _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parasomnias | <input type="checkbox"/> Oxygen use at night at liters/min: _____ |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Bruxism (teeth grinding) | <input type="checkbox"/> Epworth Sleepiness Scale score: _____ |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Periodic leg movements (PLMs) | <input type="checkbox"/> Neck Size: _____ |
| <input type="checkbox"/> History of witnessed apneas | <input type="checkbox"/> Cataplexy | <input type="checkbox"/> 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

*(Referred Out to our Partner Company)
(PPO, Medicare or cash pay only)*

1. Select a Device:

- CPAP (E0601) @ _____ cm/H2O
- APAP (Auto PAP) (E0601)
 - Default settings at 4-20 cm/H2O
 - _____/_____ cm/H2O
- Bi-level or BiPAP (E0470) @ _____/_____ cm/H2O
- Auto Bi-level or BiPAP (E0470)
 - Default settings
 - Max IPAP _____ cm H2O (4-25, default 25)
 - Min EPAP _____ cm H2O (4-25, default 4)
 - PS: _____ cm H2O (0-10, default 4)
 - Ramp time: _____ min(s) (Off-45, default 20)
- 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.