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
❐ 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, 95800, G0399 or G0400)* ❐ **Home Sleep Test** (HST) with **Oral Appliance**

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.

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