



Advanced Sleep Medicine Services, Inc.
Home Sleep Tests - Everywhere in California - Since 1994

Tel: (877) 775-3377
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www.sleepdr.com

Service Request Form

Patient Name: _____ DOB: ____/____/____ Gender: ☐ M ☐ F Height: _____ Weight: _____
Address: _____ City: _____ State: _____ ZIP: _____
Patient Email: _____ Mobile: (____) _____ Alternate: (____) _____
Insurance Company: _____ Policy #: _____

History & Symptoms:

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

Home Sleep Test (HST)

- ☐ **Home Sleep Test (HST)** (95800, 95806, or G03999) ☐ Home Sleep Test (HST) with Oral Appliance

All studies include professional interpretation by an Advanced Sleep Medicine Services, Inc. qualified physician (billed globally as a single charge)

PAP Therapy

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

1. Select a Device:

- ☐ APAP (Auto PAP) (E0601)
Default settings at 4-20 cm/H₂O
____/____ cm/H₂O

CPAP (E0601) @ _____ cm/H₂O

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 Repl. (A7032) (1 per 3 months)
Nasal Mask Pillow Repl. (A7033) (1 per 3 months)
Full-face Mask (A7030) (1 per 3 months)
Full Face Mask Cushion Repl. (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: _____

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**