Advanced Sleep Medicine Services, Inc.

Home Sleep Tests - Everywhere in California - Since 1994

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

- ❑ 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) *(95800, 95806, or G0399)* ❑ 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 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: _____

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**