SSM

*Your Solution for Sleep Disorders*

**Phone (866) 337-2536**

# Fax to (866) 639-6551

**** REMINDER TO SEND ****

- **H&P / CLINICAL NOTES**
  **DOCUMENTATION OF SLEEP DISORDER SYMPTOMS**
- **PATIENT INFORMATION SHEET**
- **COPY OF INSURANCE CARD**

## SLEEP STUDY PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

Patient Info:

Patient's Name

Date of Birth ( / / )

Patient's Address

□ M □ F
Gender

City State Zip Code

( )
Cell Phone

( )
Home Phone / Work Phone / Other Phone **(circle applicable)**

Referring Physician Info **(PLEASE PRINT)**:

Referring Physician's Name **(PRINT REQUIRED)**

Referring Physician's Address

City State Zip Code

TIN/EIN

( )
Phone Number

NPI

( )
Fax Number

## DIAGNOSIS (Required)

□ **G47.33 - Obstructive Sleep Apnea**

□ E66.2 - Morbid (Severe) Obesity With Aveolar Hypoventilation
□ F51.11 - Primary Hypersomnia
□ G47.10 - Hypersomnia, Unspecified
□ G47.30 - Sleep Apnea, Unspecified
□ G47.31 - Primary Central Sleep Apnea
□ G47.411 - Narcolepsy With Cataplexy
□ G47.419 - Narcolepsy Without Cataplexy
□ G47.50 - Parasomnia, Unspecified
□ G47.61 - Periodic Limb Movement Disorder
□ G47.8 - Other Sleep Disorders
□ Other Diagnosis: _____

## SLEEP SERVICE ORDER (Must check at least one)

☑ Diagnostic PSG With Second Night PAP Titration As Indicated On PSG Interpretation [1,2] or Identify Individual Study:

□ 95810 - Diagnostic Sleep Study (PSG)[2]
□ 95811 - Split Night Study[1,2]
□ 95800/95801 - Multiple Night Home Sleep Test
  • May Substitute G0399 or 95806 if Required By Insurance
□ 95811 - PAP Titration[1]
□ 95811 - PAP Re-Titration[1]
  • Include Prior Sleep Study Results
□ 95805 - MSLT
  • Preceded By Overnight Sleep Study (95810)
□ 95805 - MWT
  • Preceded By Overnight Sleep Study (95810)

[1]CPAP/Bi-Level at a pressure setting as was found to be the "Optimal Pressure" directly following an overnight PAP Titration Study
[2]May substitute Multiple Night HST for PSG if required by insurance **or requested by patient**

## ASSESSMENT/INDICATIONS (Check all that apply; A minimum of one in Bold is needed to qualify)

□ **Witnessed Apnea/Gasping During Sleep**
□ **Disruptive/Loud Snoring**
□ **Excessive Daytime Sleepiness**
□ **Hypertension/High Blood Pressure**
□ **Restless Sleep With Limb Movements**
□ **Unable To Perform Home Test**
□ Diabetes
□ CHF EF_____
□ BMI ≥ 50 (Morbid Obesity)
□ Sleep Walking/Talking/Parasomnias
□ CVA/Stroke
□ Nasal Obstruction
□ Low Energy/Fatigue
□ Morning Headaches
□ Depression
□ Heart Disease MI_____
□ COPD FEV_____
□ Anxiety
□ Central Sleep Apnea
□ Other: _____

## SLEEP QUESTIONNAIRE

**Neck Circumference** = _____ inches

**Epworth Sleepiness Score** =_____ (A score ≥ 10 indicates moderate to high probability of OSA)

I hereby authorize the indicated services above, within standard clinical policies & procedures. I personally conducted a physical medical examination of the patient named above for complaints of sleep disorders or other disease. The patient displayed symptoms of one or more sleep-related breathing disorders indicated above. Accordingly, I am ordering a sleep study be conducted as indicated here.

Physician Signature **(REQUIRED)**

/ / □ AM □ PM
Date and Time **(REQUIRED)**

Person Completing Medical Necessity Form / Print Name **(REQUIRED)**

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