Advanced Sleep Medicine Services, Inc.
The Sleep Experts ®

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

Service Request Form and Statement of Medical Necessity

Patient Information

Patient Name: _____ DOB: ____/____/____ Gender: ❒ M ❒ F Height: _____ Weight: _____

Address: _____ City: _____ State: _____ ZIP: _____

Best Contact Number:(____)_____ Alternate Contact Nunber. (____)_____ Email: _____

Prescribed Service(s) (Please check)

Out-of-Center or Home Sleep Testing (HST) (18 years and older)

	CPT Code
❒ Out-of-Center or Home Sleep Testing (HST), select follow up services, as needed:	95806 or G0399 (code varies by insurance)
❒ AutoPAP device set-up following unattended out-of-center (HST) test, if indicated	E0601 (please complete PAP therapy section below)
❒In-Center titration study following unattended out-of-center (HST) test, if indicated	95811

In-Center Testing (Adults and children over 1 year)

	CPT Code
❒ 50/50 split study (polysomnography with titration), select back-up services, as needed:	95811 ages 6 to adult, 95783 pediatric under 6 years old
❒ If in-center study is denied by insurance, unattended out-of-center (HST) test	95806 or G0399 (code varies by insurance)
❒ PSG / Diagnostic polysomnography	95810 ages 6 to adult, 95782 pediatric under 6 years old
❒ CPAP/BiPAP titration, select back-up services, as needed:	95811 ages 6 to adult, 95783 pediatric under 6 years old
❒If in-center study is denied by insurance, AutoPAP device set-up	E0601 (please complete PAP therapy section below)
❒ MSLT (Multiple Sleep Latency Test) following overnight polysomnography (PSG)	95805 and 95810 ages 6 to adult (95805 and 95782 pediatric under 6 years old)
Other:	

Durable Medical Equipment (DME / PAP Therapy)

Device	CPT Code	Device Settings
❒ CPAP	E0601	_____ cm H_20
❒ BILEVEL PAP	E0470	____/____ cm H_20
❒ AUTOPAP (APAP)	E0601	Default settings: 4 - 20 cm H_20
❒ ASV	E0471	EPAP min/max: ____ / ____ IPAP min/max: ____ / ____ PS min/max: ____ / ____ Rate:

For All PAP Therapy Patients:

❒ Heated Humidifier (E0562)

❒ All Relates Supplies, as needed:

Humidifier Chamber	A7046	1 per 6 months	Disposable Filters	A7038	2 per month
Nasal Mask Full Face Mask (FFM)	A7034, A7030	1 per 3 months	Non-Disposable Filters	A7039	1 per 6 months
Full Face Interface	A7031	1 per month	Tubing, 6 ft Standard Heated Tubing	A7037 A4604	1 per 3 months
Oral Cushion / Nasal Pillows Combo	A7028	2 per month	Nasal Mask Cushion Nasal Pillows	A7032 A7033	2 per month

Duration of Need: _____ (99 if lifetime for ongoing supplies as needed)

Diagnosis: _____

History & Symptoms

❒ History of witnessed apneas
❒ Loud, heavy snoring, often interrupted by gasps
❒ History of excessive daytime sleepiness (EDS)
❒ Obesity BMI: _____
❒ Heart Disease
❒ Stroke
❒ Hypertension
❒ Neck Size: _____
❒ Oxygen use at night at liters/min: _____
❒ Oxygen use during sleep study (at above settings)
❒ Epworth Sleepiness Scale score: _____
❒ Other:

Sleep Study Interpretation

❒ Interpretation by: _____

❒ Advanced Sleep Medicine Services, Inc. qualified sleep physician

If the interpreting physician is not specified, or not boarded for Medicare interpretation, an Advanced Sleep Medicine Services, Inc. qualified sleep physician will intepret the sleep study. If you select a non- Advanced Sleep Medicine Services, Inc. physician, s/he may bill seperately for interpretation.

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.

Name: _____

Ph: (____)_____ Fax: (____)_____

NPI Number: _____ Office Contact Person:_____

Physician Signature _____ Date: _____