

Prescriber Information		Physician Name:		Physician Email:	
Practice Name:			Practice Type:		
Address:		City:	State:	Zip:	
Phone:		Fax:	NPI#:		
Primary Contact:			Primary Contact Email:		

Patient Information		Patient Name: (Last)		(First)		(MI)	
Address:			City:		State:	Zip:	
Primary Phone:			Alternate Phone:			DOB:	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Email:		Patient ID#:			

Sleep History & Physical: Must select at least one

<input type="checkbox"/> Disruptive snoring	<input type="checkbox"/> Disturbed or restless sleep
<input type="checkbox"/> Non restorative sleep	<input type="checkbox"/> Witnessed apnea event during sleep
<input type="checkbox"/> Choking during sleep	<input type="checkbox"/> Gasping during sleep
<input type="checkbox"/> BMI >30	<input type="checkbox"/> Frequent unexplained arousals from sleep
<input type="checkbox"/> Excessive daytime sleepiness (EDS) as evidenced by an Epworth Sleepiness Scale > 10 (ESS)	

Diagnosis (ICD-10):

<input type="checkbox"/> Obstructive sleep apnea (G47.33)	<input type="checkbox"/> Other hypersomnia (G47.19)
<input type="checkbox"/> Hypersomnia, unspecified (G47.10)	<input type="checkbox"/> Sleep apnea, unspecified (G47.30)
<input type="checkbox"/> Idiopathic hypersomnia w/ long sleep time (G47.11)	<input type="checkbox"/> Other sleep apnea (G47.39)
<input type="checkbox"/> Idiopathic hypersomnia w/o long sleep time (G47.12)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Recurrent hypersomnia (G47.13)	

Diagnostic Service Ordered Home Sleep Test 1 night 2 nights

Please include a therapy prescription form for the patient with the sleep study report.

Physician Signature _____ **Date** _____

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

Fax Completed Prescription and Front and Back of the Patient Insurance Card to: (877) 387-6715