SLEEP SPECIALISTS MANAGEMENT LLC

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 Preferred Phone Number ____________________ ❑ YES ❑ NO Receive Text Messages? ❑ Male ❑ Female Biological Gender

REFERRAL TO SLEEP SPECIALIST

❑ **Initial Consultation & Post-Study Management** – Visit with a SSM Sleep Specialist to Evaluate and Treat

OR Complete the REQUIRED Information:

SLEEP SERVICE ORDER *(Required)*

❑ **Diagnostic PSG (95810) with Second Night PAP Titration (95811) as indicated on PSG Interpretation**[1]

❑ Multiple Night Home Sleep Test (HST) 95800/95806/G0399 [2]

[1] May substitute Multiple Night HST for PSG if required by insurance or requested by patient
[2] May substitute PSG for Multiple Night HST if required by insurance or requested by patient

ASSESSMENT / INDICATIONS *(Check all that apply. A minimum of one is needed to qualify)*

❑ **Witnessed Apnea / Gasping During Sleep** ❑ **Disruptive / Loud Snoring** ❑ **Excessive Daytime Sleepiness**

DIAGNOSIS *(Required)*

❑ **G47.10 – Hypersomnia, Unspecified** ❑ **G47.30 – Sleep Apnea, Unspecified**

OPTIONAL

❑ **Post-Study Consultation & Management** –

- Visit with a Qualified Healthcare Provider to Discuss Test Results & Initiate PAP Therapy
- Diagnostic and PAP titration studies are to be completed based upon the interpreting physician's recommendations prior to result review

PROVIDER INFO

Provider's Name ____ NPI ____ Phone Number ____ Fax Number ____

Provider's Address ____ City ____ State ____ ZIP ____

I hereby authorize the indicated services above, within standard clinical policies and 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.

Provider's Signature *(REQUIRED)* ____ / / Date *(REQUIRED)* ____ : ❑ AM ❑ PM Time *(REQUIRED)* ____ Person Completing Medical Necessity Form *(PRINT REQUIRED)* ____