Physician's Prescription & Statement of Medical Necessity
For Diagnosis of Sleep Disorders

Please fax to:

PATIENT INFORMATION

LAST:________________________FIRST: ____________________DOB: _____/_____/_____ ☐ M ☐ F

ADDRESS:________________________CITY:____________________STATE:____________ZIP:______________

PHONE:________________________EMAIL ADDRESS: ________________________

INSURANCE:________________________ID:____________________GROUP:____________________

PLEASE PROVIDE A COPY OF THE PATIENT'S INSURANCE CARD(S) AND CLINICAL NOTES

REQUESTED SERVICE/CPT CODE	DIAGNOSTIC PANEL	CO-MORBID CONDITIONS
☐ PSG 95810, Proceed with HST (95800/95806 /G0399) if criteria for PSG is not met	☐ G47.30 Sleep Apnea, Unspecified	☐ Morbid Obesity
	☐ G47.10 Hypersomnia, Unspecified	☐ Severe Pulmonary Disease
☐ PAP Titration (95811)	☐ G47.31 Primary Central Sleep Apnea	☐ Congestive Heart Failure
☐ BILEVEL Titration (95811)	☐ G47.33 Obstructive Sleep Apnea	☐ History of Stroke
☐ ASV Titration (95811)	☐ G47.411 Narcolepsy with Cataplexy	☐ Pulmonary Hypertension
☐ MSLT (95805)	☐ G47.52 REM Sleep Behavior Disorder	☐ Other _______________
☐ MWT (95805)	☐ G47.61 Periodic Limb Movement Disorder	
☐ HST (95800/95806/G0399)	☐ R09.02 Hypoxemia	
☐ Other _______________	☐ Other _______________	

INDIVIDUAL ORDERS OR SPECIAL NEEDS OF THE PATIENT: ____

The above referenced patient has an absolute medical necessity for the item(s) listed above, based on the above preliminary diagnosis. I certify that the above prescribed test(s) is/are medically indicated and, in my opinion, reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition. (A split night sleep study will be initiated by lab protocol)

SELECT INTERPRETING PHYSICIAN: ☐ No Preference ☐ _______________ ☐ _______________ ☐ _______________

REFERRING PHYSICIAN: ____ **NPI:** ____________________

ADDRESS: ____

PHONE: ____ **FAX:** ____

PHYSICIAN'S SIGNATURE: ____ **DATE:** ____________________

This section to be completed by BioSerenity Scheduling

IDTF ADDRESS: ____

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IDTF PHONE: ____