

Concierge Sleep Medicine

Sleep Study at the comfort of your home.

Referral Form

When providing an enlarged copy of Patient's Insurance Card and/or Patient Demographic/Insurance information is not necessary to complete entire form. Patient: SSN: - -Address: DOB: / / City: _____ State: ____ Zip code: ____ Home/Phone: (_____) Email Address: Primary Insurance Company:

HMO PPO POS POS POS OTHER Referring Provider: Phone Number: () City: ______ State: _____ Zip Code: _____ Fax Number:(_____) I AUTHORIZE THE FOLLOWING SLEEP STUDY (PLEASE CHECK ONE): □ **Polysomnogram** (**PSG**) (CPT 95810) 1st Night Diagnostic Study for Evaluation Only. □ CPAP / BiPAP Titration (CPT 95811) 2nd Night Titration following Diagnostic Study with DX of: □ **Split Night Study** (CPT 95811) Initial Diagnostic period followed by RDI > 40. CPAP initiation for: □ MSLT (CPT 95805) Daytime Nap Study for EDS (PSG performed the preceding night). MEDICAL NECESSITY STUDY DUE TO THE FOLLOWING SYMPTOMS: Order must have at least one primary diagnosis. *PRIMARY DX *SUPPORTING DX □ 327.23 OSA - Witnessed breathing pauses during sleep □ 786.09* Loud or Disruptive snoring □ **780.54** Excessive Daytime Sleepiness/Hypersomnia □ 780.09* Somnolence or Drowsiness □ **780.52** Insomnia of unknown etiology. □ 780.79* Fatigue or Malaise □ **347.00,01** Narcolepsy - Daytime sleep attacks □ 278.00* Obesity □ **780.51** Insomnia with apnea □ 278.01* Morbid Obesity □ **327.51** Periodic limb movements during sleep □ 307.45* Shift Work Disorder □ 333.94 Restless legs while falling asleep *Must include a PRIMARY DX. □ Other: Previous Sleep Study

Yes

No When:

Where:

Currently on CPAP:

Yes
No Since When:

Pressure:

Provider Signature: _____ *Date: