

Date	Name	Cell Phone	Home Phone
Address	City	State	Zip
DOB	SS#	Emergency Contact	Emergency Phone

Referring Physician	Phone	Fax	NPI
Insurance 1	ID	Group #	Phone
Insurance 2	ID	Group #	Phone
Height	Weight	BMI	Neck Size
Epworth Score			

Check Box Below to Select Type of Sleep Study:

- Standard Sleep Study – Split night – CPT 95810/95811
- CPAP/BiPAP titration – Full night – CPT 95811 (usually as a follow-up to a previous study)
- Multiple Sleep Latency Test – CPT 95805 (for narcolepsy – requires polysomnogram)
- Diagnostic only (adult) – CPT 95810
- Diagnostic only (pediatric) – CPT 95782

Required Documents – Include with this order form

- Copies of both primary and secondary insurance cards
- H&P
- Chart notes (signs and symptoms) for the **date of service** that is directly related to at least one of the following conditions; Sleep Apnea, narcolepsy or parasomnia

Additional Documents include if available

- Previous Sleep Test Report (PSG) if not at REM Diagnostics, Inc.
- Oximetry Report

Diagnostic Codes (Check all that apply):

<input type="checkbox"/> G47.30 Sleep Apnea	<input type="checkbox"/> G47.33 Obstructive Sleep Apnea	<input type="checkbox"/> G47.31 Central Sleep Apnea	<input type="checkbox"/> G47.50 Parasomnias
<input type="checkbox"/> G47.10 Hypersomnia unspecified	<input type="checkbox"/> G47.9 Sleep Disorder unspecified	<input type="checkbox"/> G47.52 REM Behavior Disorder	<input type="checkbox"/> G47.411 Narcolepsy/EDS
<input type="checkbox"/> G47.81 Restless Legs Syndrome	<input type="checkbox"/> R06.83 Snoring	<input type="checkbox"/> Other	

The above referenced patient has medical necessity for the procedure(s) listed above based on my preliminary diagnosis. I certify that he above prescribed procedure(s) is/are medically indicated, reasonable and necessary with reference to the standards of medical practice and treatment of the patient's condition.

Physician Signature (Please no stamps) _____ Date _____