HOME SLEEP TEST ORDER FORM

Prescription and Statement of Medical Necessity

watermarkmedical

Customer Support – 877-710-6999

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 ☐ F ☐	Email:	Patient ID#:	

Sleep History & Physical: Must select at least one

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

Diagnosis (ICD-9):

- ☐ Obstructive sleep apnea (327.23)
- ☐ Other organic sleep apnea (327.29)
- ☐ Organic hypersomnia (327.10)
- ☐ Insomnia w/ sleep apnea, unspecified (780.51)
- ☐ Idiopathic hypersomnia w/ long sleep time (327.11)
- ☐ Hypersomnia w/ sleep apnea, unspecified (780.53)
- ☐ Idiopathic hypersomnia w/o long sleep time (327.12)
- ☐ Hypersomnia, unspecified (780.54)
- ☐ Recurrent hypersomnia (327.13)
- ☐ Unspecified sleep apnea (780.57)
- ☐ Other organic hypersomnia (327.19)
- ☐ Other _____

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 <u>Front and Back</u> of the Patient Insurance Card to: (877) 387-6715