sleep metrics
In-home testing. Better sleep.

Complete and fax order to: 1-888-503-DOZE (3693)

Please Include: A front/back copy of patient's insurance
Sleep questionnaire results if available
Chart notes relating to OSA concerns

PATIENT INFORMATION

Name _____ DOB _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Alternate Phone _____

Sex **M** **F** **Height** _____ **Weight** _____ **Neck Circ.** _____

IS THE PATIENT:

Currently on CPAP? YES☐ NO☐

Currently on Oxygen? YES☐ NO☐

HAS THE PATIENT:

Taken a sleep study before? YES☐ NO☐ When? _____

Was it in a sleep lab? YES☐ NO☐

A COPY (FRONT AND BACK) OF INSURANCE CARD IS REQUIRED WITH THIS FORM*

PRESCRIPTION

(Check One): ***Unless otherwise indicated, all tests will be conducted over 2 nights to validate results*

☐ **Diagnostic Home Sleep Test**

☐ Home Sleep Test on PAP Therapy (choose one):

- ☐ CPAP therapy (to test efficacy of CPAP)
- ☐ Auto-CPAP (to determine optimal therapeutic pressure)
- ☐ BiPAP (to test efficiacy of BiPAP)
- ☐ Auto-BiPAP (to determine optimal IPAP and EPAP)

☐ Home Sleep Test on Oral Appliance (to test efficacy of mandibular device)

☐ Home Sleep Test (other indications): _____

OSA ICD-9 CODES (Check all that apply):

☐ 278.01 Morbid Obesity
☐ 327.23 Obstructive Sleep Apnea
☐ 780.51 Insomnia with Sleep Apnea
☐ 780.53 Hypersomnia with Sleep Apnea, Unspecified
☐ 780.57 UNSPECIFIED SLEEP APNEA
☐ 799.02 Hypoxemia

☐ Other Code: _____ Title: _____

Additional Instructions:

PROVIDER INFORMATION

Letter of Medical Necessity: I, the undersigned certify that the above prescribed Home Sleep Test is medically necessary as part of my medical treatment for this patient. It is my opinion that the study ordered on this form is reasonable & necessary for accepted standards of medical practice and treatment of this patient's condition.

Name _____ Phone _____ Fax _____

Address _____ State License _____

City, St, Zip _____ NPI _____

PROVIDER SIGNATURE _____ **Date** _____