Sleep Disorder Center

Rx & Certificate of Medical Necessity

►PATIENT INFORMATION

Name:_____ **D.O.B**_____

Address:_____ **City:**_____ **Zip:** _____

Phone: ( )_____ **Secondary: ( )**_____ **□ MALE □ FEMALE**

►INSURANCE INFORMATION:

Insurance Company:_____ **Company/Provider Phone:** _____

ID#_____ **Secondary Insurance Company:**_____

►DX:

□Obstructive Sleep Apnea **□Central Sleep Apnea** **□Complex Sleep Apnea** **□Hypertension** **□COPD**

□Snoring **□Hypoxemia** **□Ischemia** **□Insomnia** **□PLMD**

□Narcolepsy **□Heart Disease** **□Restless Leg Syndrome** **□Nightmares** **□CHF**

□Excessive Daytime Sleepiness **□Other:**_____

►SLEEP DIAGNOSTIC TESTING ORDERED:

□95805 Multiple Sleep Latency Test (MSLT)

□95810 Overnight Polysomnography

□95811 Follow up CPAP/BiPAP Study

□95806 Home Sleep Test

□ 50/50 Split Study (for qualifying patient)

□ Electroencephalogram (EEG)

□ Consultation

□Other/Notes:_____

_____

_____

►PHYSICIAN INFORMATION:

Name:_____

Physical Address:

_____

_____

Phone: (805)_____ **Fax: (805)**_____

State License#:_____ **DEA #:**_____ **NPI #:**_____

Physician Signature: _____ **Date:** _____/_____/_____ **Office Contact:**_____