ACCREDITED
AASM American Academy of SLEEP MEDICINE™

Medicare CERTIFIED

SLEEP CARE & CPAP CENTER

Helping you sleep better···So you can live better.

PATIENT NAME _____DOB_____TEL. NO_____

INSURANCE NAME_____INS ID: _____

RX/CERTIFICATE OF MEDICAL NECESSITY

FAX WITH CHART NOTES & INS INFO TO (909) 987-3536 OR E-fax (626) 357-4300

SLEEP STUDY ORDER

( ) DIAGNOSTIC CPT 95810 *(Diagnostic to rule out OSA (obstructive sleep apnea)*
( ) CPAP/BI-PAP/AUTO SV - CPT 95811 *(Previous OSA diagnosis / CPAP titration to update pressure settings)*
( ) SPLIT NIGHT STUDY - CPT 95811 (*Diagnosis and Treatment in one night)*
( ) HOME SLEEP TEST CPT 95800/95806/G0399 (*Unattended Home Sleep Study – Screening test)*
( ) INSRUANCE AUTHORIZED SLEEP TEST (*Sleep test pursuant to PT plan & authorization)*

MEDICAL NECESSITY

( )Snoring ( )Witnessed Apnea ( )Fatigue ( )Headaches ( )Obesity ( )RLS ( )Insomnia ( )COPD ( )CHF
( )Pulmonary Hypertension ( )Hypertension/Heart Disease ( )Arrhythmias ( )Stroke/Heart attack history
Other conditions_____

TREATMENT OPTIONS

( ) CPAP/BIPAP MACHINE AFTER SLEEP STUDY TEST (*treatment set up with physician RX & Ins authorization)*
( ) CPAP @_____cmH20 **( ) AUTO-CPAP** (4-20cm H20) ____/____cm/H2O **( ) Bi-PAP** at____/____cm/H2O
( ) SUPPLIES *(Mask, Cushions, Tubing, Filters)* **( )** Length of Need: _____ *(99 months = Lifetime)*
( ) OTHER: _____

MEDICAL NECESSITY CERTIFICATION

PHYSICIAN NAME _____NPI _____

SIGNATURE_____DATE_____

I certify that this patient is under my care and the prescribed diagnostic test/treatment is medically necessary and within the standards of medical practice for this patient's condition.

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