Feeling Great!

Sleep Medical Centers
Doctor Consultations, Sleep Testing
CPAP & Oxygen Equipment
Your All-In-One Sleep Solution
www.FeelingGreatSleepCenter.com

Call
919-477-1588 or 866-499-1588
Fax
919-477-1688 or 866-499-1288

The Physician Guide on the Back of this Form Provides Clinical Information for Documentation

MANDATORY REQUIREMENTS FOR MEDICARE & INSURANCE COMPANIES

Please *Check, Fax,* and *Send* the following clinical information: Fax 919-477-1688

- ☐ **Physician's 'face-to-face' notes must provide the correct diagnoses necessary prior to Sleep Study or DME equipment.**
- ☐ **Clinical notes are required for insurance authorization and to avoid insurance denials for Sleep Studies or DME.**
- ☐ **If the physician does not have the necessary documentation for the Sleep Study, a consultation with our Board Certified Sleep Specialist can be scheduled in order to evaluate the patient.**
- ☐ **Please fax sleep study results from other sleep centers.**

PATIENT INFORMATION

Name _____ Gender ( ) M ( ) F Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Primary Insurance: _____ Policy # _____

Secondary Insurance:_____ Policy # _____

CERTIFICATE OF MEDICAL NECESSITY – PRESCRIPTION(S) – Sold to Patient

SLEEP STUDY

( ) PSG, ( ) CPAP/BiPAP, ( ) MSLT, ( ) MWT, ( ) Split

Reason for Study:

( ) R/O OSA, ( ) Narcolepsy, ( ) HTN, ( ) H/O CVA,
( ) H/O CHF, ( ) Hypersomnia, ( ) H/O Heart Disease
( ) Excessive Daytime Sleepiness (EDS), ( ) Sleep Apnea
Other Sleep Disturbance _____

All patients ordered a diagnostic sleep study will be scheduled for additional sleep studies based on our sleep specialists' recommendation unless checked below.

If you decline any further sleep tests after this order, Please Check Here: _____

Prescriptions for sleep studies include Durable Medical Equipment (Alice Sleep System) and all of the related medical supplies. These supplies include, and are not limited to: gloves, medical tape, lemon prep, oximetry supplies, nasal cannulas, EKG, EEG and all other medical supplies **which are sold to the patient and used by the patient/consumer as supplied** under this prescription under the billable codes: PSG 95810, CPAP titration 95811, MSLT / MWT 95805

CPAP/BiPAP

( ) CPAP ( ) Bipap ( ) Pressure change
( ) Mask ( ) Tubing ( ) Replacement Supplies
( ) Humidifier ( ) Heated, ( ) Cool

Dx if AHI 15 or >: ___ OSA (G47.33), ___ COPD (J44/1)
___ Central Apnea (G47.31)

If AHI is less than 15, a secondary diagnosis is required:
____ EDS, ____ HTN, ____ Insomnia, ____ h/o CVA

- CPAP @ _____ cm H2O
- BiPAP-S @ I_____, E _____ cm H2O
- BiPAP-ST @ I_____, E _____ cm H2O
- BiPAP-ST @ _____ back-up rate ventilation

Prescriptions for all DME (Oxygen, CPAP/BiPAP) includes all DME and related medical supplies which are sold to the patient as supplied under the prescription CMN (Certificate of Medical Necessity).

SLEEP PHYSICIAN CONSULTATION

( ) NEW patient consultation with Board Certified Sleep Specialists

- Evaluate Patient Prior to Sleep Study ( )
- Follow-up after Sleep Study ( )

Evaluation needed to assess / treat:

Sleep Apnea ( ), Insomnia ( ), Narcolepsy ( )
Epilepsy ( ), Night Terrors ( ), REM Disorders ( )
Restless Legs ( ), Other ( ) _____

OXYGEN

Dx: COPD – J44.1 ( ), CHF – I50.9 ( ), Other _____
Home Oxygen: _____ Portable Needed: Yes ( ), No ( )
Room Air 02 Sat:_____ (qualifying < 88%) Date:_____
RA Sat done at: Within 2 days of Hosp D/C ( ), Home ( )
Physician's Office ( ), Other _____
02 treatment @ ____ LPM via nasal cannula, ____ hrs

Continuously _____, with sleep only _____
Estimated Length of Need: _____ 99 = Lifetime, Other _____
Standard Continuous Flow Regulator _____
Conserving Device Regulator _____ (MD ensures sats > 90%)

Print MD Name _____ Group Name _____

Address _____

Phone # _____ Fax # _____

I certify that I am the treating physician and I have had a face-to-face evaluation with this patient prior to ordering these services. I have completed this Certificate of Medical Necessity form and any statements here have been reviewed and signed by me. I certify that the medical information is true, accurate, and complete to the best of my knowledge. I certify that the above test / equipment ordered are medically necessary in the treatment of this patient.

Physician Signature _____ **NPI #** _____ **Date** _____