



**1 Patient Information**

Patient Name: \_\_\_\_\_  Male  Female DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Primary Ins:  Medicare  Commercial Plan: \_\_\_\_\_ ID #: \_\_\_\_\_

**Nationally Accepted Insurances: Humana, Medicare, Tricare, BCBS, Aetna, Coventry, Cigna & Medicare Advantage Plans**

Secondary Ins: \_\_\_\_\_ ID #: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ FT \_\_\_\_\_ IN Neck Circumference: \_\_\_\_\_ IN BMI: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ NPI: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Local DME Supplier: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**2 Face-to-Face Clinical Exam: Required to be documented in patient's medical record.**

Sleep History & Symptoms: **(Check ALL that are applicable)**

- Snoring  Daytime Sleepiness  Observed Apneas  Choking or Gasping during Sleep  Morning Headaches  
 Tired/Fatigued  Other (Describe Nature): \_\_\_\_\_

Focused CardioPulmonary & Upper Airway Evaluation: **(Check ALL that are applicable)**

- Large Tongue  Enlarged Tonsils  Large Uvula  Overbite  Under bite  Crowded Oropharynx  
 Worn Teeth  Nasal Obstruction  Hypertension  Obesity  Other (Describe Nature): \_\_\_\_\_

Epworth Sleepiness Scale: **How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?**

- 0 – **NO** chance of dozing      1 – **SLIGHT** chance of dozing      2 – **MODERATE** chance of dozing      3 – **HIGH** chance of dozing  
\_\_\_\_ Sitting & Reading      \_\_\_\_ In car stopped in traffic for few mins.      \_\_\_\_ Sitting inactive in public      \_\_\_\_ Lying down to rest in afternoon  
\_\_\_\_ Watching TV      \_\_\_\_ Passenger in Car for hour w/o break      \_\_\_\_ Sitting quietly after lunch w/o alcohol      \_\_\_\_ Sitting & Talking

Epworth Score: \_\_\_\_\_ **(Normal Epworth Score is considered below 8)**

**3 Prescription for Diagnostic Procedure**

Diagnosis: **(At least one to be checked)**

- G47.30 – Unspecified Sleep Apnea       G47.33 – Obstructive Sleep Apnea (Use this for suspected or to confirm OSA)  
 G47.10 – Hypersomnia, unspecified       R09.02 – Hypoxemia

Home Sleep Test: G0399 – Home Sleep Test on room air (Type III Portable Monitor, minimum of four channels)  One Night  Two Night

**Physician Certification** I, the undersigned, certify that I have completed the requirements according to CMS guidelines prior to ordering this Home Sleep Test for the patient noted above. I further agree that this order is not for screening purposes of an asymptomatic patient and understand that CMS coverage guidelines require a **face – to – face evaluation**, relating to section three above, must be documented in the patient's medical chart prior to a HST is ordered. I allow & have informed my patient that the test kit may be delivered and billed by a third party. **By signing below, I find that it is medically necessary to have this Home Sleep Test completed.**

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**4 FAX COMPLETED FORM WITH INSURANCE CARD(S) TO DMT/HMV AT (866) 624-1411**