

**Patient's information**

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work/other phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Marital status:  M  S Sex:  M  F

**Referring provider's information**

Person completing form: \_\_\_\_\_

Referring physician's name: \_\_\_\_\_ NPI number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

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

**Insurance information**

**Please fax enlarged copy of front and back of insurance card**

Insurance company name: \_\_\_\_\_ Policy/ID: \_\_\_\_\_ Group: \_\_\_\_\_

Customer service/benefits phone: \_\_\_\_\_ Policy holder: \_\_\_\_\_ DOB: \_\_\_\_\_

**Indications**

**The sleep related complaints or diagnoses include:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Sleep apnea, obstructive (327.23)               | <input type="checkbox"/> Hypersomnia, non-organic origin (307.43)       | <input type="checkbox"/> RLS/PLMS (327.52)                                     |
| <input type="checkbox"/> Sleep apnea, suspected (327.20)                 | <input type="checkbox"/> Daytime sleepiness (307.44)                    | <input type="checkbox"/> Period limb movement disorder (327.51)                |
| <input type="checkbox"/> Sleep apnea, unspecified† (780.57)              | <input type="checkbox"/> Diabetes (250.00)                              | <input type="checkbox"/> Sleep related movement disorder, unspecified (780.58) |
| <input type="checkbox"/> Sleep apnea with insomnia (327.00)              | <input type="checkbox"/> Hypertension, unspecified (401.9)              | <input type="checkbox"/> Morbid obesity (278.01)                               |
| <input type="checkbox"/> Insomnia with sleep apnea, unspecified (780.51) | <input type="checkbox"/> Hypertension (401.1)                           | <input type="checkbox"/> Snoring (786.09)                                      |
| <input type="checkbox"/> Insomnia (307.42)                               | <input type="checkbox"/> Epilepsy/recurrent seizures (345.80)           | <input type="checkbox"/> Circadian rhythm sleep disorder, unspecified (327.30) |
| <input type="checkbox"/> Narcolepsy (347.0)                              | <input type="checkbox"/> CHT, unspecified (428.00)                      | <input type="checkbox"/> Seizure disorder (345.9)                              |
| <input type="checkbox"/> Parasomnia, organic† (327.40)                   | <input type="checkbox"/> Cerebral artery occlusion, unspecified (434.9) | <input type="checkbox"/> Nocturia (788.43)                                     |

**Referring provider's orders**

**The following selected procedure is ordered:**

- 95810 Attended comprehensive sleep testing (Includes pre-study and/or post-study consultation with sleep specialist at Nocturna Sleep 95811 Clinic and the ordering of treatment as needed)** If criteria are met for split night titration (AHI $\geq$ 40 or AHI $\geq$  20 if appropriate co-morbid risks are present and at least two hours of sleep during diagnostic recording) or if emergency guidelines of the supervising physician are met, a split night titration (95811) is ordered. If criteria for split night titration are not met, a polysomnogram (1st night) (95810) is ordered. If the polysomnogram (1st night) is positive for sleep apnea, a CPAP titration (2nd night) (95811) is ordered. If the polysomnogram is negative for sleep apnea and the patient is being evaluated for excessive daytime sleepiness, a multiple sleep latency test (95805) is ordered. If the patient meets criteria for CPAP/BiLevel PAP treatment, I authorize Nocturna Sleep Therapy in initiate CPAP/BiLevel PAP therapy.  
 Referring provider will provide all pre-study and post-study consultations and comprehensive management.  
 Referring provider will arrange the patient's CPAP/BiLevel set-up.
- 95810 Diagnostic sleep study (Polysomnogram)**  
 A CPAP titration (95811) is ordered if emergency guidelines of supervising physician are met.  
 If the Polysomnogram is positive for sleep apnea, A CPAP titration (2nd night) (95811) is ordered.
- 95811 Nasal CPAP titration study**
- 95805 Multiple sleep latency test (MSLT)**
- 95811 CPAP re-titration study**
- Other (describe):** \_\_\_\_\_

**Please fax: (1) recent office notes with clinical indication; and (2) copy of insurance cards(s)**

Ordering physician's signature \_\_\_\_\_ Date \_\_\_\_\_

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 Home phone: \_\_\_\_\_  
 Email address: \_\_\_\_\_ Marital status:  M  Sex:  M  F

**Please fax this page to  
 254-399-6939  
 for additional referral pads.**

\_\_\_\_\_  
**Physician's office**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Contact person**

**Referring provider's information**

Referring physician's name: \_\_\_\_\_ NPI number: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Insurance company name: \_\_\_\_\_ Group: \_\_\_\_\_  
 Customer service/benefits phone: \_\_\_\_\_ DOB: \_\_\_\_\_

**Insurance information**

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