



Phone: (352) 293-2810

[www.dynamicdiagnostic.com](http://www.dynamicdiagnostic.com)

Fax: (352) 274-9122

Patient Information

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

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

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

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

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

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

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

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

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

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

Patient Diagnosis

Diagnosis: At least one must be checked to process prescription request

- 327.10 ORGANIC HYPERSOMNIA, UNSPECIFIED
327.20 ORGANIC SLEEP APNEA, UNSPECIFIED
327.21 PRIMARY CENTRAL SLEEP APNEA
327.23 OBSTRUCTIVE SLEEP APNEA (ADULT)
327.27 CENTRAL SLEEP APNEA CLASSIFIED ELSEWHERE
327.29 OTHER ORGANIC SLEEP APNEA
327.40 ORGANIC PARASOMNIA, UNSPECIFIED
327.41 CONFUSIONAL AROUSALS
327.42 REM SLEEP BEHAVIOR DISORDER
327.43 RECURRENT ISOLATED SLEEP PARALYSIS
327.44 PARASOMNIA CLASSIFIED ELSEWHERE
780.54 HYPERSOMNIA, UNSPECIFIED
780.51 INSOMNIA WITH SLEEP APNEA, UNSPEC.
780.53 HYPERSOMNIA WITH SLEEP APNEA, UNSPECIFIED
780.57 UNSPECIFIED SLEEP APNEA
799.02 HYPOXEMIA
Other:

Diagnostic Procedure

Home Sleep Test (HST) Procedure: Please check one box only

- Type II/Type III HST Device used to aide in diagnosing patients with suspected sleep apnea. Sleep Test to be completed on "Room Air" with a Type II or Type III device.
Type III HST Device used to aide in diagnosing patients with suspected sleep apnea. Sleep Test to be completed on "Oxygen" with a Type III device at specified liter flow below.

Patient Testing on Oxygen - Test on:  1 LPM  2 LPM  3 LPM  4 LPM  Other: \_\_\_\_\_ LPM

Physician Certification

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 must be documented in the patient's medical chart prior to a HST is ordered. By signing below, I find that it is medically necessary to have this Home Sleep Test completed and that I have completed the requirements of Epworth Sleepiness Scale, Face-to-Face Clinical Evaluation and reviewed the Sleep History & Symptoms with the patient above.

Physician Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE FAX A COPY OF PATIENT'S INSURANCE CARDS WITH THIS FORM TO: (352) 274-9122. THANK YOU