

Patient Name: _____

Primary Insurance: _____

DOB: _____

Member ID: _____

Phone: _____

For faster processing, please fill in all information above and attach the following:

Demographics, Insurance Cards, Last Office Notes, Medications List and any Sleep Studies not completed by Z Sleep.

IN LAB DIAGNOSTIC AND THERAPEUTIC SLEEP STUDIES

- DIAGNOSTIC/PSG** (95810) – No CPAP therapy initiated even when patient is positive for sleep apnea
- SPLIT NIGHT** (95811) – Diagnostic sleep study followed by CPAP titration if patient meets criteria
- TITRATION** (95811) – Treatment sleep study only. Used when patient has had a sleep study within the past 5 years and a baseline is not necessary. **YOU MUST CHOOSE ONE OF THE FOLLOWING:**
 - CPAP BIPAP ASV
- MULTIPLE SLEEP LATENCY TEST** (MSLT) (95805) – Used when narcolepsy is suspected. **MUST BE PROCEEDED BY PSG OR SPLIT. PLEASE CHOOSE ABOVE.**

HOME SLEEP STUDIES *(Do not choose if IN LAB has been requested above)*

- HOME SLEEP TEST** (95806) - Used to detect obstructive sleep apnea in people with a moderate-to-high risk
- PULSE OXIMETRY** (94762) - Continuously measures blood oxygen saturation and heart rate during sleep

POSITIVE AIRWAY PRESSURE (PAP) THERAPY

<input type="checkbox"/> CPAP (E0601) _____ cm H2O	<input type="checkbox"/> AUTO TITRATING CPAP (E0601) _____ to _____ cm H2O
<input type="checkbox"/> BIPAP (E0470) _____ IPAP _____ EPAP cm H2O	<input type="checkbox"/> AUTO BIPAP (E0470) _____ MaxIPAP _____ MinIPAP CMH2O _____ PS
<input type="checkbox"/> ASV (E0471) _____ EPAP _____ MaxPS _____ MinPS	<input type="checkbox"/> AUTO ASV (E0471) _____ MaxEPAP _____ MinEPAP cmH2O _____ MaxPS _____ MinPS
<input type="checkbox"/> Heated humidifier for chronic sinus symptoms and/or allergies	<input type="checkbox"/> All disposables (mask, headgear, tubing, filters)

PROVISIONAL DIAGNOSIS <input type="checkbox"/> Obstructive Sleep Apnea (G47.33) <input type="checkbox"/> Unspecified Sleep Apnea (G47.30) <input type="checkbox"/> Hypersomnia (G47.10)	PRESENTING SYMPTOMS <input type="checkbox"/> Excessive Snoring (R06.83) <input type="checkbox"/> Daytime Somnolence (R40.0) <input type="checkbox"/> Other Sleep Apnea (G47.39)
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Physician Signature _____

Physician Printed _____

Date _____