SLEEP THERAPY
SOLUTIONS

1340 Corporate Drive Suite 200, Hudson, OH 44236
Ph: 330-655-0630 / 866-858-9480 Fax: 330-655-0632

PHYSICIAN ORDER FOR CLINICAL SERVICES / INTAKE FORM

Name: _____ DOB: _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone:_____ Work Phone: _____

Primary Insurance Carrier: _____ ID# _____
Secondary Insurance Carrier: _____ ID# _____

Diagnosis: _____ ICD-9: _____ Length of Need:_____
(1-99, 99=lifetime)

Physician's Order:

□ **HOME SLEEP TESTING (G0399)**

□ **SLEEP STUDY(PSG) (95810)**
□ **TITRATION STUDY (95811)**

□ **NOCTURNAL OXIMETRY**
□ **COMPREHENSIVE OXIMETRY**

□ **CPAP THERAPY: _____cmH2O (E0601)**
□ **AUTO CPAP THERAPY: _____ to _____ cmH2O (E0601)**
□ **BILEVEL THERAPY: IPAP: _____cmH2O, EPAP: _____cmH2O (E0470)**
□ **AUTO BILEVEL THERAPY: IPAP MAX: _____cmH2O, EPAP MIN: _____cmH2O (E0470)**
□ **HEATED HUMIDITY (E0562)**
□ **SUPPLIES (As defined below)**

FULL FACE MASK (A7030) 1 EVERY 3 MONTHS	HEADGEAR(A7035) 1 EVERY 6 MONTHS
FULL FACE CUSHION(A7031) 1 EVERY MONTH	CHINSTRAP(A7036) 1 EVERY 6 MONTHS
NASAL MASK(A7034) 1 EVERY 3 MONTHS	TUBING(A7037)(A4604) 1 EVERY 6 MONTHS
NASAL CUSHION(A7032) 2 EVERY MONTH	DISPOSABLE FILTERS(A7038) 2 EVERY MONTH
NASAL PILLOWS(A7033) 2 EVERY MONTH	NON-DISPOSABLE FILTERS(A7039) 1 EVERY 3 MONTHS
HUMIDIFIER CHAMBER(A7039) 1 EVERY 6 MONTHS	ORAL/NASAL MASK(A7027) 1 EVERY 3 MONTHS

□ **OXYGEN: LPM: _____ Frequency: _____**

□ **OTHER: _____**

Physician Name:_____

Address: _____

UPIN: _____ NPI: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____