Merit Sleep Disorder Testing CPAP Therapy Sleep Center Management

SLEEP STUDY ORDER FORM

MERIT SLEEP CENTERS

Phone: (888) 637-4848 Fax: (630) 506-5329

SERVICE REQUEST FORM AND STATEMENT OF MEDICAL NECESSITY

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____
Address:_____
City/State:_____
Phone (Home):_____ (Cell):_____ (Work)_____
Insurance Name:_____ Policy ID/Group #:_____
Email: _____

PRESCRIBED SERVICE(S)

You are REQUIRED to choose one of the following:

- ☐ Sleep study **WITH** specialist consultation to review sleep study results and initiate appropriate therapy.
- ☐ Sleep study **WITHOUT** specialist consultation. PCP/ordering physician will review sleep study results and initiate appropriate therapy.
- ☐ Other:_____

DIAGNOSIS (REQUIRED)

- ☐ G47.33 Obstructive Sleep Apnea
- ☐ G47.00 Insomnia
- ☐ G47.31 Central Sleep Apnea, primary
- ☐ E66.2 Obesity Hypoventilation Syndrome
- ☐ G47.61 Periodic Limb Movement Disorder
- ☐ Other _____

SYMPTOMS / MEDICAL CONDITIONS / MEDICATIONS (MUST BECOMPLETED)

Insurance requires physician supporting documentation for the following:

- ☐ Snoring
- ☐ Daytime sleepiness
- ☐ Witnessed apnea
- ☐ Restless legs
- ☐ Shortness of breath
- ☐ Patient is currently on oxygen
- ☐ Moderate/severe pulmonary disease
- ☐ Moderate/severe CHF
- ☐ Mood disorder
- ☐ Neuromuscular Impairment
- ☐ Cognitive impairment resulting in an inability to follow simple instructions
- ☐ Suspicion of sleep disorder other than OSA (central sleep apnea, periodic limb movement disorder, circadian rhythm disorder, parasomnias)

REPORTING RESULTS

☐ **Send copy of professional interpretation to the following:**

Physician/Dentist Name: _____ Contact Information: _____

I certify that the above service(s) prescribed by me is/are medically indicated and in my opinion is/are reasonable and necessary with reference to all professionally recognized medical standards and treatment of this patient's condition.

If patient's insurance denies In Lab sleep study then proceed with Home Sleep Test.

Ordering Physician **Signature** **Date**

Please fax this form and attachments to (630) 506-5329 or submit referrals online at www.meritsleep.com.