Home Sleep Test Order Form

Call 586-225-8500 or email support@sleepathome.net to inquire about using our online portal to order home sleep tests!

Instructions: Have the patient complete sections A, B, and C, and the provider complete the rest of the form. Along with chart notes/progress notes, fax to 586-225-8585 or upload to the sleepathome® Portal.

PLEASE NOTE: Neuromuscular disease, congestive heart failure, and moderate to severe pulmonary disease are comorbidities for home sleep testing. In-lab testing is preferred when other sleep disorders (I.E. narcolepsy, insomnia) are suspected. Patients with these conditions should meet with a specialist to discuss their qualifications for sleep testing.

A: PATIENT INFORMATION – Only name and date of birth required if submitting order via the sleepathome® Portal			
Last Name:	First Name:	Language (If not English):	
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Unspecified	Height:	Weight:
Address **(Include apartment #. Cannot use P.O. Box):**			
City:		State:	Zip code:
Cell Phone:	Home Phone:	Email:	

B: PAYMENT/INSURANCE			
MUST CHECK ONE: ☐ Patient requests **self-payment of $220** ☐ Patient requests **insurance billing: complete below section unless submitting order via the sleepathome® Portal**			
Primary Plan:	Subscriber ID:	Policy Holder:	Group #:
Secondary Plan:	Subscriber ID:	Policy Holder:	Group #:

C: EPWORTH SLEEPINESS SCALE			
Instructions: Grade each situation with a value of 0-3, depending on how likely you are to doze off or fall asleep in each situation. 0 = no chance of dozing, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high chance of dozing			
Sitting and reading:		Lying down to rest in the afternoon when circumstances permit:	
Watching TV:		Sitting and talking to someone:	
Sitting inactive in a public place, like a theater or in a meeting:		Sitting quietly after a lunch without alcohol:	
Sitting as a passenger in a car for about an hour without a break:		Sitting in a car, while stopped for a few minutes:	
Total Epworth score - add all values from each question: 0-7 = low risk, 8-11 = moderate risk, 12-15 = high risk, 16+ = severe risk			

D: PRESCRIBER INFORMATION – Only provider name required if submitting order via the sleepathome® Portal			
Provider Name:	Phone #:	Fax #:	NPI:

E: DIAGNOSIS/MEDICAL HISTORY/SYMPTOMS			
ICD-10 Code G47.33 (Obstructive Sleep Apnea) will be used for this home sleep test unless specified otherwise:			
Medical Necessity of Home Sleep Testing: ***1. Certain Payers require as many as four (4) symptoms but at least two (2). Please check all that apply.*** ***2. Certain Payers require medical documentation/progress notes regarding testing for Sleep Apnea. Please attach these.***			
☐ Witnessed Apneic Events	☐ Habitual Snoring/Gasping/Choking	☐ Excessive Daytime Sleepiness	
☐ Hypertension	☐ Previous Diagnosis of OSA	☐ Coronary Artery Disease	
☐ Atrial Fibrillation	☐ History of Stroke	☐ Other (Specify):	
☐ Test will be performed using oral appliance			
TEST TYPE - *Home Sleep Test (CPT: 95806/G3099)*			

By signing below, I attest that: upon my examination of the patient, which included HEENT, Cardiovascular, Chest/Lung, Neurological and Vital Signs, there is a high probability of OSA. A Home Sleep Test is medically necessary, and no co-morbid conditions are present that prevent the patient from home testing.

Ordering Physician's Signature **Date**