PROGRESSIVE HOME MEDICAL Setting the Standard

After Hours Pager 602.852.1776

Fax 480.895.2949

Phone 480.802 0202

******Valley Wide Service******

Referred by_____

Patient's Name: _____Date of Birth: _____
Address: _____City: _____ Zip:_____

Patient's Phone: (Home) _____ (Cell) _____ (Work) _____

******Please Send a Copy of All Insurance Information With This Form******

Diagnostic Sleep Testing

Type of Testing Requested

❒ **Home Sleep Study**

❒ **Split PSG** 95811 (Initiate PAP if Medicare/AASM AHI>15hr)

❒ PAP Titration (Previous Diagnostic Study Required)

❒ Consultation by a sleep certified physician

❒ Excessive Daytime Sleepiness ❒Other_____

Indications For Sleep Testing

❒ Observed Apneas/Witnessed ❒ Snoring

❒ Cardiovascular Disease ❒ Obesity

******Please fax patient's CHART NOTES & Ins. Card*** ***

PHYSICIAN'S ADDRESS STAMP AND PHONE NUMBER

Diagnosis:

❒ Obesity E66.9 ❒ Excessive Daytime Sleepiness G47.19
❒ Fatigue R53.83 ❒ Obstructive Sleep Apnea G47.33
❒ Snoring R06.83 ❒ Witnessed Apnea G47.30
❒ Hypertension I10 ❒ Insomnia G47.00
❒ Hypersomnia G47.3 ❒ GERD K21.9

Length of Need: ☒ Lifetime ❒ Other:_____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity on this form is true, accurate, and complete, to the best of my knowledge.

PHYSICIAN'S SIGNATURE: _____DATE: ____/_____/_____

Print Physician's Name_____