

HOME SLEEP TEST (HST) ORDER FORM:  
Submit via Fax to: 1-866-216-5200  
or: 410-630-5845

You may also order online at:  
[www.novasom.com/easyorder](http://www.novasom.com/easyorder)  
For assistance, call 1-877-753-3776

*For faster processing, please complete all sections below and confirm the patient's current phone number.*

**PLEASE NOTE:** Patients who require chronic oxygen therapy should have an attended, in-lab sleep test and not an AccuSom Home Sleep Test. We also do not test patients while using CPAP. By sending this order to NovaSom, you are attesting that the patient can have a Home Sleep Test.

PRESCRIBER INFORMATION			
Ordering Provider Name:	Phone #:	Fax #:	NPI:
Office Contact Name:		Phone# (If applicable, include extension #):	
PATIENT INFORMATION			
Last Name:	First Name:	Language (If not English):	
Date of Birth (mm/dd/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:
Address (Include apartment #. Unable to deliver to a P.O. Box):			
City:		State:	Zip code:
Cell Phone (include area code):	Home Phone:	Email:	
PAYMENT/INSURANCE			
<b>MUST CHECK ONE:</b>			
Patient requests self-payment of \$297: <input type="checkbox"/> Charged in three (3) credit card installments of \$99 each.			
Patient requests insurance billing: <input type="checkbox"/> <b>Attach copy of both front &amp; back of insurance card and complete section below.</b>			
Primary Plan:	Subscriber ID:	Policy Holder Name:	Policy Holder Birth Date:
Secondary Plan:	Subscriber ID:	Policy Holder Name:	Policy Holder Birth Date:
DIAGNOSIS/MEDICAL HISTORY/SYMPTOMS			
ICD-10 Code G47.33 will be used for this Obstructive Sleep Apnea (OSA) test unless specified otherwise. (If other, specify):			
<b>Medical Necessity of Home Sleep Testing:</b>			
1. Certain Payers require as many as four (4) symptoms but at least two (2). Please check <u>all</u> that apply.			
2. Certain Payers require medical documentation/progress notes regarding testing for Sleep Apnea. Please attach these.			
<input type="checkbox"/> Witnessed Apneic Events	<input type="checkbox"/> Habitual Snoring (R06.83)	<input type="checkbox"/> Excessive Daytime Sleepiness	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Previous Diagnosis of OSA	<input type="checkbox"/> Gasping/Choking	
<input type="checkbox"/> Non Restorative Sleep	<input type="checkbox"/> Drowsy Driving	<input type="checkbox"/> Morning Headaches	
<input type="checkbox"/> Test with Oral Appliance	<input type="checkbox"/> Other (Specify):		
Does Patient have CHF? <input type="checkbox"/> YES Does Patient have COPD? <input type="checkbox"/> YES If YES, What is the severity? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Enter Epworth Sleepiness Scale Score (Range 0 – 24; ≥ 10 = High Risk):			
TEST TYPE - Home Sleep Test Only will be administered if nothing is checked below.			
<input type="checkbox"/> Home Sleep Test Only (An up to three-night Sleep Test will be administered based upon ordering provider or payer)			
<input type="checkbox"/> Titration Test Only	If Sleep Test was not done by NovaSom, supply date of last Sleep Test:		AHI:
DESIGNATED THERAPY/DURABLE MEDICAL EQUIPMENT (DME) PROVIDER AND RELEASE OF TEST RESULTS			
By entering contact information below, provider directs that any test results (whether positive or negative) additionally be sent to the therapy/DME provider for purposes of treatment of the patient.			
Therapy/DME Provider Name:	Phone #:	Fax #:	

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.

Provider's Original Signature (Stamped Signatures Not Accepted)

Date