Fax: 805-682-1936
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2323 Oak Park Lane, #200
Santa Barbara, CA 93105

SLEEPMED
Science. Systems. Solutions.

Physician's Prescription & Statement of Medical Necessity

Last Name_____ Middle Initial_____ First Name_____
Gender: Male_____ Female_____ Height _____ Weight _____ BMI _____Neck Size_____
Date of Birth _____ Social Security# _____
Address _____
City _____ Zip Code _____
Home Phone _____Work Phone _____
Cell Phone _____Email Address_____
Insurance _____

PLEASE PROVIDE: (COPY OF INSURANCE CARD, DEMOGRAPHICS & HISTORY/PHYSICAL)

DIAGNOSTIC SERVICES:

_____**POLYSOMNOGRAPHY**	(CPT-95810) Diagnostic
_____**POLYSOMNOGRAPHY W/ CPAP TITRATION**	(CPT-95811) Diagnostic w/CPAP pressure determination
_____**CPAP TITRATION**	(CPT-95811) CPAP
_____**ASV/VPAP TITRATION**	(CPT-95811) ASV/VPAP Titration
_____**BILEVEL TITRATION**	(CPT-95811) BiLevel
_____**MULTIPLE SLEEP LATENCY TEST**	(CPT-95805) Day Study
_____**NOCTURNAL PULSE OXIMETRY**	(CPT-94762) Unattended

DURABLE MEDICAL EQUIPMENT (DME):

_____**CPAP (E0601) Pressure Settings** _____**cm H2O** _____Pressure determined by Sleep Study

_____**BIPAP (E0470) Pressure Settings IPAP**_____**cm H2O**

EPAP_____**cm H2O**_____Pressure determined by Sleep Study

_____**AUTOCPAP (E0601) Pressure Settings** _____to_____ cmH2O

_____**VPAP ADAPT SV (E0471) Pressure settings** **EPP** _____**cmH2O**_____ Pressure determined by Sleep Study

$IPAP_{min}$ _____ cm H_2O $IPAP_{max}$ _____ cm H_2O

HUMIDIFIER: YES NO _____ **HEATED** (E0562) _____ **PASSOVER** (E0561)

ANCILLARY SUPPLIES: The following supplies will be included or replaced, as needed, unless otherwise indicated.

☐ Mask (A7034, A7044, A7030, A7027)	☐ Headgear (A7035)	☐ Chinstrap (A7036)
☐ Tubing for CPAP (A7037)	☐ Tubing for Heated Humidifier (A4604)	☐ Nasal Pillows (A7033, A7029)
☐ Nasal Cushion (A7032, A7028)	☐ Face Mask Interface (A7031)	☐ Exhalation Port (A7045)
☐ Filter, Disposable (A7038)	☐ Filter, Non-Disposable (A7039)	☐ Water Chamber for Humidifier (A7046)

☐ *Other (please describe):*_____

The above referenced patient has an absolute medical necessity for the item(s) listed above, based on the following diagnosis:____APNEA (327.23) or other:_____. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition. **The duration of this equipment will be lifetime unless otherwise indicated here**: _____

REFERRING PHYSICIAN:_____
ADDRESS:_____
City: _____ **State:**_____ **Zip:** _____
Tel:_____ **Fax:** _____
CONTACT: _____ **NPI#:**_____

INTERPRETING PHYSICIAN:

☐ Victor Rosenfeld, M.D.
☐ Hsien Young, M.D.
☐ Charles Curatalo, M.D.
☐ Charles Schroeder, M.D.

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____