



Phone: 888-49-SLEEP (75337) Fax: 1-866-348-1398

CPAP/BILEVEL Order Form & Letter of Medical Necessity

Patient Demographic Information

Person Making Referral:	Phone #:
Date:	
Patient Name:	Gender:
Date of Sleep Study:	SSN# : DOB:
Home Address:	Home Phone:
	Work Phone:
Emergency Contact:	Contact Phone:
Primary Insurance:	Subscriber ID #:
Authorization #:	Group #:
Secondary Insurance:	Policy #:
Address:	Group #:
Sleep Lab Where Study Conducted:	

Patient Clinical Information

Diagnosis: OSA	Apnea / Hypopnea Index:
Total # of Apneas/Hypopneas:	Total # of Recorded Time:
Total # of Hours of Sleep:	MD Office Phone #:
Ordering MD:	UPIN #: NPI #:
MD License #:	<input type="checkbox"/> Bi-level pressure: cmH ₂ O
<input type="checkbox"/> CPAP pressure: cm H ₂ O	Ramp: minutes
<input type="checkbox"/> Supplemental Nocturnal O ₂ :	<input type="checkbox"/> Other Specifications:
<input type="checkbox"/> Nasal Mask A7034 <input type="checkbox"/> Full Mask A7030 SIZE:	
Humidifier: <input checked="" type="checkbox"/> HEATED E0562 <input type="checkbox"/> NON-Heated E0561	<input type="checkbox"/> Chinstrap A7036
<input checked="" type="checkbox"/> Tubing A7037	<input checked="" type="checkbox"/> Head Gear A7035
Length of Need: Lifetime	Frequency of Change for Supplies: PRN

Physician Signature: _____

Date: _____

Date of Face-to-Face visit prior to ordering sleep test: _____

Date of Face-to-Face re-evaluation (between 31st & 91st day): _____

Treating Physician: _____