Rest Easy with...
SMS
SLEEP MANAGEMENT SOLUTIONS

Phone: 888-49-SLEEP (75337) Fax: 1-866-877-2714

CPAP/BILEVEL PA 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: **Fallon Community Health Plan**	Subscriber ID #:
Authorization #:	Group #:
Secondary Insurance: Address:	Policy #: 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 #:	[ ] Bi-level pressure: cmH_20
☐ CPAP pressure: cm H_20	Ramp: minutes
☐ Supplemental Nocturnal O2:	☐ Other Specifications:
☐ Nasal Mask A7034 ☐ Full Mask A7030 SIZE:	
Humidifier: ☐ HEATED E0562 ☐ NON-Heated E0561	☐ Chinstrap A7036
☐ Tubing A7037	☐ 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: _____