SLEEP STUDY CERTIFICATION REQUEST FORM

PH: 800-630-3493 FX: 866-999-3510

SMS SLEEP MANAGEMENT SOLUTIONS

The following Sleep Intake form must be completed for all sleep testing procedures.

Patient name:		**DOB:**	
Insurance plan:		**Member ID #:**	
Patient address:		City, state, zip:	
Home Phone #:	Cell Phone		Work Phone #:
Epworth Sleepiness Score *Required* (see worksheet):		BMI:	or Height: / Weight:
Ordering Physician:		MD Signature (Required)	
Physician address:		City, state, zip:	
Physician Phone #:		Physician fax #:	

I. Study Requested: Is this a repeat study request: ☐ YES ☐ NO

If a 95810 is requested, but only a G0399 approved, may the G0399 home study be substituted? ☐ YES ☐ NO

☐ G 0399 (95806, G0398) Home Sleep Test
☐ 95810 (95807/8) Polysomnography – Attended
☐ 95811 Polysomnography – Attended with initiation of Therapy
☐ 95805 Multiple Sleep Latency Testing

Participating Site if a Facility Based Study is authorized:

1. Name__________________ TIN ____________ 2. Name: __________________ TIN____________

II. Clinical Information (check all that apply) (For Repeat Studies complete A, B, C for new onset symptoms):

A. Complaint(s):

☐ Disruptive snoring ☐ Excessive daytime sleepiness ☐ Disturbed or restless sleep ☐ Non-restorative sleep

B. Signs and Symptom(s): ☐ Witnessed apnea events, choking or gasping ☐ Frequent unexplained arousals ☐ Non-ambulatory individual ☐ Nocturia

C. Symptom Duration: ☐ < one month ☐ ≥ one month ☐ ≥ three months ☐ ≥ six months

D. Co-morbid conditions (Recent supporting office notes required):

☐ Unexplained pulm hypertension ☐ Stage III or IV COPD/Lung Disease ☐ Class III or IV Heart Failure
☐ Significant, persistent cardiac arrhythmia not controlled with meds ☐ Suspected Nocturnal seizures
☐ Neuromuscular weakness and impaired respiratory function ☐ CMPLX SDB/CAH
☐ Neurodegenerative Disorders/Cognitive Impairment preventing HST ☐ Suspected narcolepsy
☐ Low risk of OSA (all that apply): △ Normal BMI △ No snoring △ Normal neck circumference
△ No Family Hx OSA △ No sedating meds △ Non-smoking △ Normal airway (Mallampati classification)

Comorbid Dx Duration: ☐ < one month ☐ ≥ one month ☐ ≥ three months ☐ ≥ six months

E. Medications and Miscellaneous: ☐ SSRI ☐ Pain Control or Sedating medications ☐ Pt is night shift worker

F. Repeat Study Indication: ☐ Change in BMI >5 ☐ Recent T/A, UPP , MMA ☐ New Symptoms/Other ____________

G. PAP Compliance for Repeat Studies: PAP used > 2 months ☐ YES ☐ NO
PAP therapy 4+ hours on 70% of nights ☐ YES ☐ NO

DEFINITIONS: HST = home sleep study; NPSG = in lab polysomnogram; EDS = excessive daytime sleepiness; ESS = Epworth Sleepiness Scale; BMI = body mass index; COPD = Chronic Obstructive Pulmonary Disease; CMPLX SDB = Complex Sleep Disordered Breathing; CAH = Central Alveolar Hypoventilation; MSLT = multiple sleep

latency test; MWT = maintenance of wakefulness test; SSRI = Selective Serotonin Reuptake Inhibitor; T/A = Tonsillectomy/Adenoidectomy; UPP = Uvulopalatoplasty; MMA = Maxillomandibular Advancement Surgery

EPWORTH SLEEPINESS SCALE

MUST BE COMPLETED FOR AUTHORIZATION

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation Chance of Dozing or Sleeping	Scale
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	

Total score equals your ESS	

0 – 9 Average score, normal population

Physician's signature____**Date**______________________________