SLEEPSTAT

HOME SLEEP TEST (HST) REFERRAL FORM

Patient Name (First and Last) _____ **Sex** _____ **Date of Birth** _____

Insurance Information

HST can be ordered for the following insurances. We will be updating this list, as more insurance companies approve HST. Please call us, if the insurance company is not listed here and allow us to check Benefits and Eligibility for that policy.

- ❑ Aetna
- ❑ BCBS Blue Cross Blue Shield
- ❑ Coventry/First Health
- ❑ Humana
- ❑ Medicare
- ❑ Tricare
- ❑ United Healthcare

Physician or Practitioner Information

Physician Name _____ **NPI** _____ **Phone** _____ **Fax** _____

Step 1 - Sleep History and Physical (check all that apply)

- ❑ Sleep disordered breathing
- ❑ Loud snoring
- ❑ Excessive daytime somnolence
- ❑ Observed apnea
- ❑ Morning headaches
- ❑ Awakening gasping for breath
- ❑ Non-restorative sleep
- ❑ Morning dry mouth
- ❑ Depression

Step 2 - Physical Exam

Height _____ **inches** **Weight** _____ **lbs** **BMI** _____ **Neck Circumference** _____ **inches**

Step 3 - Diagnosis

- ❑ Obstructive Sleep Apnea
- ❑ Unspecified Sleep Apnea
- ❑ Insomnia with OSA
- ❑ Hypoxemia
- ❑ Morning headaches
- ❑ Awakening gasping for breath

Step 4 - Order to Perform Home Sleep Test (HST)

- ❑ Perform a 2-night Level III Home Sleep Test (CPT 95800) on room air
  Level III test consists of Pulse Oximetry, Heart Rate, Nasal Airflow, Chest Movement, EEG, EOG, EMG

Step 5 - Practitioner Signature and Attestation

I am the patient's treating Practitioner and I have ordered this test based upon a face-to-face comprehensive sleep evaluation for this patient and have determined that this patient has a high pretest probability of moderate to severe Obstructive Sleep Apnea.

Additionally, this patient (select one):

- ❑ Is not known to have moderate to severe pulmonary disease, neuromuscular disease or congestive heart failure, or
- ❑ Cannot get patient in for an attended polysomnogram.

I am prescribing a 2-night serial HST; which is medically necessary to validate results because of night-to-night variability.

Practitioner Signature _____ **Printed Name and Title** _____ **Date** _____

Helpful Hints:

Complete Steps 1 thru 5. Provide a copy of the patient's insurance card and demographic information. Include a copy of the History and Physical (H&P) noting the sleep concerns. Fax documents and completed HST Order Form to Fax **1-855-634-7296**.