



Sleep Study Prior Authorization Request Form

Phone: 866-827-5861 FAX: 866-536-8046

Portal: www.sleepsms.com or www.carecentrixportal.com

For prior authorization requests, visit www.sleepsms.com or www.carecentrixportal.com to submit online or fax the following:

Entire completed form Medication list Updated clinical notes

Insurance Plan:	Patient Subscriber ID#:	Diagnosis Code:
Patient First Name:	Last Name:	DOB:
Patient Address:	City:	State/
Patient Phone:	Height:	Weight: BMI:
Ordering Physician Name:	Physician NPI: (Required)	
Ordering Physician Address:	City:	State/Zip:
Physician Phone #:	()	Physician Fax #: ()

I. Study Requested (code definitions are on page 3):

Unattended Home Sleep Test (HST): _____ G0399

Facility diagnostic sleep test: _____ 95810 _____ 95805 _____ 95811(full night) _____ 95811 (split night)
Pediatric < 6 years old _____ 95782 _____ 95783

If a facility based diagnostic test is requested and patient qualifies for a home study, may the home study be substituted?
___ Yes ___ No* *If No, please provide reason and select co-morbidity in Section III.B or non OSA suspected sleep disorder in Section III. C. Attach all supportive clinical evidence.

If attended titration study is requested, but patient qualifies for auto positive pressure machine (APAP), may the APAP be substituted? ___ Yes ___ No *If No, please provide reason and supportive clinical evidence.

Is this a Request for a repeat study? ___ Yes* ___ No *If Yes, date of last study: _____

Repeat study only: _____ Weight change > 10% _____ Recent T/A or UPPP _____ Other
Has PAP been used > 2 mos. ___ Yes ___ No 70% of usage 4+ hours per 24 hour period night:
_____ Yes ___ No

II. Preferred sleep test provider(s), please list below (CareCentrix reserves the right to assign a provider):

Billing Facility Name: Address: _____

Phone: _____ Fax: _____ Tax ID: _____ NPI: _____

HST Provider: _____ Address: _____

Phone: _____ Fax: _____ Tax ID: _____ NPI: _____

Patient's HST Delivery Preference: Ship to Home _____ Pick up at the sleep center (if available) _____

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E. Current Medications:

Submitting medication list No prescriptions or OTC medications
 Check here if patient is taking any medications in these categories: SSRI Pain controlling or sedating

F. Special Needs:

Occupational or social limitations (specify): _____

Is an alternate language spoken (specify): _____

G. Additional Notes:

IV. Reference Table of Codes and Descriptions

Code	Description
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
95806	Home sleep test (HST), simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort
95808	Polysomnography; any age, sleep staging with 1 to 3 additional parameters of sleep, attended by a technologist
95810	Polysomnography; age 18 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811	Polysomnography, age 18 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
95811	Split-night in-facility polysomnography, in which the initial diagnostic portion of the polysomnography is followed by positive airway pressure (PAP) titration, as medically necessary in an adult (age 18 or older)
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist with an initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist