Rest Easy with... SMS SLEEP MANAGEMENT SOLUTIONS

Phone: 888-49-SLEEP (75337) Fax: 1-866-217-2053

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: **MVP Health Care** Authorization #:	Subscriber ID #: Group #:
Secondary Insurance: Address:	Policy #: Group #:
Sleep Lab Where Study Conducted:	

Patient Clinical Information

Diagnosis: OSA – 327.23	Apnea / Hypopnea Index:
Total # of Apneas/Hypopneas:	Total # of Recorded Time:
Total # of Hours of Sleep:	MD Office Phone #: Fax#:
Ordering MD:	UPIN #: NPI #:
BMI: Neck Circumference:	**Epworth Sleepiness Scale Score:**
MD License #:	☐ Bi-level pressure: cmH_20
☐ CPAP pressure: cm H_20	Ramp: minutes
☐ Supplemental Nocturnal O2: ☐ Nasal Mask A7034 ☐ Full Mask A7030 SIZE:	☐ Other Specifications:
Humidifier: ☐ HEATED E0562 ☐ NON-Heated E0561	☐ Chinstrap A7036 ☐ ___ - Filters A7038-Disp ☐ ___ - Filters A7039 - Non
☐ Tubing A7037	☐ Head Gear A7035
Length of Need: **lifetime**	Frequency of Change for Supplies: **90 to 180 Days**

Physician Signature:_____ **Date:** _____

Date of Face-to-Face visit prior to ordering sleep test: _____ **(must be completed)**

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