WellPointe
SLEEP DIAGNOSTIC CENTER

Please fax completed form to:
(888) 977-3829
Telephone: (866) 693-7360

CPAP

SLEEP STUDY REQUISITION FORM

	Ordering Physician	UPIN#	Ordering Facility Phone #			
	Ordering Facility		Referring Physician Phone # ( )			
PATIENT INFORMATION (All Spaces must be filled to process prescription)	Patient's Name					
	Home Address		Home Phone # ( )			
	City State ZIP+4		Birth Date	Sex	Age	
	Other Contact Name		Phone# ( )			
INSURANCE INFORMATION (Submit copies of insurance cards)	**Primary Insurance Company** (only fill out if different from previous test)		**Secondary Insurance Company**			
	Policy #	Group #	Policy #	Group #		
	Name of Policy Holder	Birthdate of Policy Holder	Name of Policy Holder	Birthdate of Policy Holder		
	Insurance Address		Insurance Address			
	City State		City State			
	ZIP+4	Phone # ( )	ZIP+4	Phone # ( )		
	Referral/Authorization Number/Other Billing Information/Comments					

SLEEP HISTORY:

- ☐ Excessive Daytime Sleepiness
- ☐ Loud Snoring
- ☐ Witnessed Apnea
- ☐ Waking Up Gasping or Choking
- ☐ Trouble Falling Asleep
- ☐ Trouble Maintaining Sleep
- ☐ Body Paralysis Triggered by Emotions (Cataplexy)

DIAGNOSIS:

- ☐ Obstructive sleep apnea 327.23
- ☐ Central sleep apnea 327.21

TEST(S) ORDERED:

- ☐ Sleep Consultation with follow-up, if needed
- ☐ CPAP Titration - 95811

PHYSICIAN STATEMENT

I certify that I have ordered this test out of medical necessity in order to treat or diagnose this patient. I also agree to provide documentation upon request. This test is not for screening purposes.

Physician Signature _____ **Date** _____

PATIENT TERMS AND CONDITIONS

This agreement is by and between WellPointe Sleep Diagnostic Center, LLC (hereinafter "WPSC") and the above-described patient (hereinafter "Patient"). Your physician has prescribed a sleep study to be able to diagnose or further treat you. WPSC and Patient agree to the following terms and conditions:

1. Patient authorizes the release of any and all medical information necessary to obtain an insurance payment for this service.
2. Patient agrees that WPSC is entitled to payment of all authorized benefits, both primary and secondary payments. WPSC agrees to accept assignment on all Medical and some private insurance company claims, and Patient agrees to be fully responsible for any deductible, co-pays or non-reimbursable services, which can be paid by Visa, MC, AMEX and Discover. Patient understands that health insurance is not a guaranteed payer, only a source of payment. Patient represents that the information set forth above is accurate and correct and that Patient has read and understands all of the terms and conditions of this agreement.

You are not required to go to this facility to have your study, however if you choose to go elsewhere, please make sure that you get copies of the test results to us before your next visit.

I HAVE READ THE ABOVE AND HEREBY APPROVE AND CONSENT TO ALL TERMS THEREIN CONTAINED.

Patient Signature: _____ **Date:** _____