*For Sleep Consultation fill out sections A, B, C, D and H (Physician Signature Required)

WellPointe

SLEEP DIAGNOSTIC CENTER

PSG

SLEEP STUDY REQUISITION FORM

Please fax completed form to: (888) 977-3829

Any Questions? (866) 693-7360

www.wellpointesleep.com

A

REFERRING PHYSICIAN	NPI#	Referring Facility Phone #:
Referring Facility		Ordering Sleep Physician

B

PATIENT'S NAME				
Home Address		Home Phone # Cell Phone #		
City State ZIP		DOB:	Sex	Age
Other Contact Name		Phone# ( )		

C

PRIMARY INSURANCE COMPANY (or fax information to us)		**Secondary Insurance Company**	
Policy #	Group #	Policy #	Group #
Name of Policy Holder	DOB of Policy Holder	Name of Policy Holder	DOB of Policy Holder

D

INDICATIONS FOR A SLEEP STUDY

- ☐ HF (Heart Failure) NYHA Class III &IV, EF (Ejection Fraction) less than 50%, or Class II Diastolic Dysfunction
- ☐ Cardiac arrhythmia (e.g. atrial fibrillation, SVT, ventricular arrhythmia (diagnosis):_____
- ☐ Moderate to severe pulmonary disease (e.g. chronic respiratory disease/ symptomatic lung disease/ pulmonary hypertension) (diagnosis): _____
- ☐ Neuromuscular Disease (diagnosis):_____
- ☐ Cognitive impairment or other social circumstances that compromise administration of a home sleep test (HST)
- ☐ Stroke within the last 12 months
- ☐ Suspicion of other sleep disorder(suspected diagnosis: Central Sleep Apnea REM Behavior Disorder):_____
- ☐ Body Mass Index(BMI) > 33 and elevated serum bicarbonate level (>28 mmol/L)

E

SLEEP HISTORY:

- ☐ Excessive Daytime Sleepiness
- ☐ Loud Snoring
- ☐ Witnessed Apnea
- ☐ Waking Up Gasping or Choking
- ☐ Periodic Limb Movements/ Restless legs/leg jerks
- ☐ Trouble Falling Asleep
- ☐ Trouble Maintaining Sleep
- ☐ Body Paralysis Triggered by Emotions (Cataplexy)

F

PAST MEDICAL HISTORY:

- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Cerebral Vascular Accident
- ☐ Diabetes Mellitus
- ☐ Cardiac Arrhythmia
- ☐ Other _____
- ☐ Seizure

G

MEDICATIONS:

PHYSICAL EXAM:			Lung:
HT:	WT:	Neck Size:	Heart:
Throat:			Abdomen:

H

TEST ORDERED: (Select one only)

* ☐ Sleep consultation. (Complete sections A, B, C, D and H (physician signature required))

- ☐ Sleep Study (Polysomnography/PSG) only - 95810 (if sleep apnea is suspected)
- ☐ Sleep Study (Polysomnography) with Multiple Sleep Latency Test (MSLT) - 95805 (if the diagnosis of narcolepsy is suspected)
- ☐ Home Sleep Test – HST - (requires prior sleep consultation)

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.	Case reviewed and approved by the Medical Director
Physician Signature:_____ **Date**:_____	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.

Patient is not required to go to this facility to have the study. However if patient chooses to go to another facility. Patient should send copies of the test results to WPSC before the next visit.

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

Patient Signature:_____ **Date:** _____